CALIFORNIA HEALTH LAW NEWS

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California Health Law News (CHLN) is a quarterly publication of the California Society for Healthcare Attorneys (CSHA). The mission of CHLN and the CSHA Publications Committee is to publish articles that are interesting and useful to health lawyers practicing California law. While the Publications Committee strives to ensure that CHLN articles provide accurate and authoritative information regarding the subject matters covered, the information is provided with the understanding that neither CSHA nor CHLN contributors are engaged in rendering legal services. Contributors to CHLN are not agents of CSHA and the opinions and positions stated in CHLN articles are those of the authors and not of CSHA, its staff, the CHLN editors or Publications Committee members.

EDITORS' NOTE

Ben Durie

Carla Hartley

Dear CHLN Readers –

We hope that 2023 is off to a great start for everyone. We are excited to bring you our first issue of the year. This issue contains a variety of articles that is a testament to CSHA's membership and the hard work of the Publications Committee. From the annual Legislative Update to articles on AB 1130, California's Healthcare Accountability and Affordability Act, the No Surprises Act, California Business and Professions Code section 650 and permissible compensation arrangements, Med Spa Oversight, and our second installment on the implications of *Dobbs v. Jackson Women's Health Organization* from a California perspective, we have something for everyone.

A new year brings new changes to CHLN. Ben Durie will be stepping down as an editor as he assumes the CSHA presidency. Kate Broderick will be joining us as co-editor. The Publications Committee is also seeking new members. Members interested in assisting CHLN to continue offering timely and diverse articles, in particular with a California perspective of benefit to the CSHA membership, please contact Carla Hartley (cjh@dillinghammurphy.com) and Ben Durie (Benjamin.Durie@UCSF.edu) by March 31, 2023.

We also encourage all members, and non-members, to reach out with ideas for articles. We want CHLN to continue offering the best and most innovative publications for the California healthcare attorney community. Please contact us even if you are not interested in writing the article yourself as CSHA includes a wealth of potential authors. Also, please continue to send member news to Karen Weinstein (kweinstein@memorialcare.org) so that our community can stay up to date on your latest news.

As a reminder, we have the Annual Meeting and Spring Seminar coming up May 5 through 7, 2023 at the Renaissance Esmeralda Resort and Spa in Indian Wells. That will be preceded on May 4 by the second annual California Healthcare Law Essentials, a daylong intensive course specifically designed for healthcare attorneys in their first five years of practice. Last year's Essentials got rave reviews and is a great crash course in the vast and complex field of healthcare law.

Finally, we encourage all members to join CSHA's LinkedIn Group so that we can continue growing our vibrant online forum.

Ben and Carla

ANNOUNCEMENTS

CONGRATULATIONS TO MEMBERSHIP DRIVE RAFFLE WINNERS

Four returning CSHA members were the lucky winners of the membership renewal raffle held earlier this year. All CSHA members who submitted their renewals by January 12 were entered into a drawing for a $100 Amazon Gift Card. The four winners include Kim Morimoto of Sutter Health, a seven-year member, Wesley Dodd of Office of the County Counsel, County of Santa Clara, who joined CSHA in 2017, Hillary Hershenow of California Department of Health Care Services, a four-year member, and Jeffrey D. Barlow of Molina Healthcare, Inc., whose first year with CSHA was 2005.

The Membership Committee thanks all of the CSHA members who renewed their membership for 2023 and offers congratulations to the lucky winners!

2023 ANNUAL MEETING AND SPRING SEMINAR

The CSHA 2023 Annual Meeting & Spring Seminar will be held May 5–7, 2023, at the beautiful Renaissance

Esmeralda Resort & Spa in Indian Wells. This year's program offers 12 hours of MCLE credit and will feature presentations on:

- Common Pitfalls with Physician Recruitments
- Fostering a Just Culture to Promote Patient Safety: Legal and Regulatory Challenges
- What Every Healthcare Attorney Needs to Know About Employment law – A Primer
- Defending Healthcare Entities Against Class Actions Based on the Use of Website Cookies and Pixels
- Chief Diversity Officers and Partners
- Hot Topics in Managed Care Reimbursement
- Update: Implementation of the No Surprises Act and the Independent Dispute Resolution Process
- Health Litigation Update
- Involuntary Psychiatric Holds and Due Process Rights: What's New in 2023
- California's Skilled Nursing Sector: Crisis, Reaction & Opportunity
- Navigating the 340B Universe: Critical Developments and Practice Points
- Identifying Red Flags for California Public Agencies
- Ethical Considerations Involved in the In-House/Outside Counsel Relationship

Weekend sessions are scheduled in the mornings, leaving afternoons free for you and your family to enjoy the Palm Springs area. Our Friday evening Welcome Reception and Saturday evening Annual Dinner (with entertainment) provide opportunities to network with your fellow health law colleagues!

CSHA has reserved a limited number of rooms at the Renaissance Esmeralda Resort & Spa starting at a nightly rate of $294, plus resort fee and tax.

To make your reservation, call the hotel at (800) 446-9875 and ask for the California Society for Healthcare Attorneys (CSHA 2023 spring seminar) group rate. The deadline for obtaining the discounted rate is April 7, 2023.

Visit www.csha.info/ to view the agenda, seminar brochure and to register online.

2023 CARLO COPPO HEARING OFFICER TRAINING PROGRAM

We are pleased to announce a full-day training program presented by the Hearing Officer Committee, which will take place in Indian Wells on May 4, immediately before the CSHA Annual Meeting & Spring Seminar the next day. This program will cover important aspects of the hearing officer's role and responsibilities, including:

- Handling voir dire of the hearing officer and Judicial Review Committee candidates
- Ruling on disputes over discovery and evidentiary and procedural issues
- Advising the Judicial Review Committee
- Drafting the decision
- Maintaining a hearing officer's record
- Anticipating appellate issues
- Attending this program satisfies the ongoing training requirement for inclusion on the CSHA Hearing Officer listings.

We are confident this array of topics, being presented in lecture and role-play vignette format, will be interesting and educational for everyone who serves as a hearing officer, aspires to become a hearing officer, or who appears before hearing officers as an advocate for a party to a JRC hearing.

Learn more and register at www.csha.info/2023-cc-hearing-officer-program.

2023 CALIFORNIA HEALTHCARE LAW ESSENTIALS

CSHA is pleased to announce that on May 4, 2023, it will reprise its day-long course designed for healthcare attorneys in their first five years of practice.

Essentials focuses on the parts of California law that differ from or go beyond national trends in healthcare law. This material is often not taught in law school courses – but knowledge of these fundamental topics is usually assumed in many other CSHA educational presentations. The faculty are seasoned experts in the fields they are presenting and teaching.

To participate in Essentials this year, you must be (1) a current or new member of CSHA; (2) have practiced for no more than five years (or be new to the practice of California healthcare law in 2023); and (3) be willing to both review the course materials before May 4, 2023, and come prepared for an intensive, interactive learning experience about California healthcare law.

Essentials will be held at the same location as the CSHA Annual Meeting & Spring Seminar (Renaissance Esmeralda Resort & Spa, Indian Wells), and participants are encouraged to register for that event as well.

Learn more and register at www.csha.info/2023-csha-essentials.

NEW MEMBERS

Kendra Anderson
Scripps Health
San Diego, CA

Currun Arora
White | Canepa LLP
Madera, CA

Pamala Blane
Rady Children's Hospital
San Diego, CA

Brian Bewley
Manatt, Phelps & Phillips, LLP
Washington, DC

Bailey Bifoss
Seyfarth Shaw LLP
San Francisco, CA

Anna Capati
Leucadia, CA

Marco Dell'Oro
Manhattan Beach, CA

Gaurav Dhiman
Nossaman
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Stephen Fleischer-Ihn
Delta Dental of California
San Francisco, CA

M. Kathleen Gallagher
DSR Health Law
Sacramento, CA

Sheirin Ghoddoucy
California Medical Association
Sacramento, CA

John Gray
Department of Health Care
Access and Information
Sacramento, CA

Lindsey Greenblatt
King & Spalding LLP
Los Angeles, CA

Kent Grover
Hanson Bridgett LLP
Los Angeles, CA

Nurhassan Guiamelon
Department of Health Care Services
Sacramento, CA

Adrienne Gundry
Sharp HealthCare
San Diego, CA

Alyssa Guthrie
San Diego, CA

Pamela Hamilton
Cedars-Sinai
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C. Brandi Hannagan
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U.S. Attorney's Office
Los Angeles, CA

Katherine Hwang
California Department of Justice/
Office of Attorney General
San Diego, CA

Natalie Ann James
Salinas Valley Memorial
Healthcare System
Salinas, CA

Christopher C. Jew
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Los Angeles, CA

Christine P. Johnson
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Erica Koscher
California Department of Justice
San Francisco, CA

Danthanh (Danni) Lam
California Department of
Corrections & Rehabilitation
Elk Grove, CA

Hye Jin Lee
Polsinelli
Los Angeles, CA

Denise Ma
Madison, WI

Will Maguire
CDPH
Sacramento, CA

William Mavity
King & Spalding LLP
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Jim Mehlhaff
San Mateo County
Redwood City, Ca

Kathryn Merrill
Sacramento, CA

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San Diego, CA

Kaylin Sangimino
Department of Managed Healthcare
Sacramento, CA

Anne Schneider
Fenton Law Group, LLP
Los Angeles, CA

Jackson Smithers
Poway, CA

Stephen Steinberg
Bartko Zunkel Bunzel & Miller
San Francisco, CA

Jason Wright
Jones Day
Los Angeles, CA

MEMBER NEWS

KATHERINE ADDISON moved to Aya Healthcare in July 2022.

BETTY CLARK joined the Department of Managed Health Care as an Attorney III in October 2022.

MARGIA CORNER became Senior Principal Counsel at for the University of California in September 2022.

DR. SHERYL DASCO became Of Counsel at Greenberg Taurig LLP in October 2022.

KATHRYN EDGERTON joined Mintz as a Member in the firm's Health Practice in Los Angeles in October 2022.

ROBERT W. HODGES has retired from the practice of law. Happy retirement, Bob!

TERRI KEVILLE, a partner at Davis Wright Tremaine, was recently appointed to the Editorial Board of *The Health Lawyer*, the magazine of the ABA Health Law Section. CSHA members are invited to reach out to Terri if they're interested in authoring nationally focused articles on virtually any health law topic.

MICHAELA LOZANO LEWIS was promoted to Assistant County Counsel of the County of Santa Clara in August 2022.

LANCE MARTIN joined Cigna as Legal Counsel in August 2022.

JULIA MICHAEL has been promoted to Senior Counsel at Kaiser Permanente.

SANSAN LIN MURRAY is Counsel for Kaiser Permanente as of August 2022.

LESLIE MURPHY and **JOHN BARNES** have joined David Wright Tremaine as partners, effective November 2022.

BELLA OLMEDO joined Buchanan Ingersoll and Rooney as an Associate in October 2022.

PHILLIP SAUD became General Counsel of Nexus HR Services in November 2022.

WENDY SOE-MCKEEMAN began serving as Director of Regulatory Affairs at Beacon Health Options in October 2022.

RUSSELL TAYLOR moved to Nassiri & Young LLP as a Senior Litigator in September 2022.

NISHA VERMA became a partner at Dorey & Whitney in September 2022.

ANNA WANG rejoined Inland Empire Health Plan to serve as VP, Chief Legal Officer in October 2022.

NICOLE WASYLKIW moved to the California Chamber of Commerce in November to serve as Corporate Counsel in November 2022.

Effective October 2022, **JERED WILSON** is VP Payer Relations, Health and Wellness at Walmart.

Since August 2022, **MAHNOOR YUNUS** has served as Medical-Legal Partnership Network Fellow for the UCSF/UC Hastings Consortium on Law, Science & Health Policy

2022 REPORT ON LEGISLATION

Edited by **Lois Richardson**
California Hospital Association

Following are brief descriptions of the healthcare implications of the state's 2022-2023 budget as well as healthcare-related bills enacted during the second year of California's 2021-22 legislative session. The full text of the budget bills and each new law are available at http://leginfo.legislature.ca.gov/. The budget took effect on July 1, 2022. Urgency bills are listed with the date they became effective. All other measures take effect Jan. 1, 2023.

STATE BUDGET

This year's budget
In June 2022, the Legislature and governor approved a $308 billion budget for the state fiscal year extending from July 2022 through June 2023. Revisions to the budget continued to be made through the end of the legislative session, which generally redirect, build upon, or provide statutory parameters around actions previously taken. Below is a summary of key health care-related actions in the 2022-23 budget package.

HEALTH CARE WORKFORCE

- **Health Care Workforce Investments.** Commits $1.5 billion over the next three years to support health care workforce development programs, including:
    - Nursing ($357 million)
    - Community health workers ($281 million)
    - Behavioral health ($226 million), primary care ($45 million), reproductive health ($40 million), and others.

The Department of Health Care Access and Information (HCAI) will serve as the administering agency for most of the programs. Guidance on how to access these funds will be released in the coming months by the administering departments.

- **Hospital and Nursing Home Worker Retention Pay.** The budget provides nearly $1.1 billion in state funding to hospitals and nursing homes to make retention payments to their workers. Workers will be eligible for payments of up to $1,500 from the state, with state support varying based on hospital and nursing homes making qualifying payments to their workers.

COVERAGE EXPANSIONS

- **Comprehensive Medi-Cal Coverage for All Undocumented Immigrants.** The budget approves the expansion of full-scope Medi-Cal coverage to otherwise eligible undocumented immigrants ages 26-49. This is the last remaining age group of undocumented immigrants currently ineligible for full-scope coverage. Implementation is slated to occur in January 2024. With this and other Medi-Cal changes, nearly all Medi-Cal beneficiaries are expected to be enrolled in Medi-Cal managed care.
- **Continuous Medi-Cal Eligibility for Children Under Age 5.** Contingent upon a future determination by the Department of Finance that state funding can support this change, Medi-Cal eligibility redeterminations for children under age 5 will be

prohibited — except in limited circumstances, such as when a child moves out of state, dies, or is voluntarily disenrolled by a family member. This policy would take effect in January 2025.

BEHAVIORAL HEALTH

- **The Community Assistance, Recovery, and Empowerment (CARE) Act.** The budget funds, and companion legislation authorizes, the CARE Act — otherwise known as CARE Court. This is the framework for the delivery of behavioral health services for individuals with the most serious behavioral health needs, including individuals who are homeless and/or at risk of incarceration. The CARE process is intended to serve as a diversion pathway from conservatorship. The October 2023 implementation will initially be limited to a cohort of counties — Glenn, Orange, Riverside, San Diego, San Francisco, Stanislaus, and Tuolumne. The budget allocates a one-time $26 million for the first cohort of counties, and $31 million for all counties, to plan and prepare for statewide implementation. An additional $31 million is provided to the judicial branch, the Department of Health Care Services, and the California Health and Human Services Agency to support implementation.
- **Behavioral Health Bridge Housing.** The budget provides $1.5 billion over two years for cities and counties to provide bridge housing (such as board and care facilities and acquiring tiny homes) and behavioral health services for individuals experiencing homelessness.
- **Children's Behavioral Health Package.** The budget provides $290 million over three years to address urgent youth mental health issues through school-based peer mental health services, the development of resources for parents to support their children's mental health, a youth suicide reporting and crisis response pilot program, the development of digital supports for remote mental health assessment and intervention, and a program to attract high school students who are considering entering the behavioral health profession. This package builds upon the $4.4 billion investment in 2021 in the Children and Youth Behavioral Health Initiative.
- **Mobile Crisis Intervention as a Medi-Cal Benefit.** The budget provides $108 million to counties to implement a new statewide mobile crisis intervention Medi-Cal benefit starting in January 2023. The benefit will build upon existing crisis intervention services delivered by counties.
- **Los Angeles County Incompetency-to-Stand-Trial Services and Supports.** The budget includes $100 million from the General Fund for Los Angeles County to support and expand access to treatment for moderately-to-severely mentally ill, justice-involved individuals. This includes through the construction, acquisition, or rehabilitation of a mental health care treatment facility or facilities.
- **Opioid Package.** The budget includes a $42 million package to support substance use disorder workforce development, naloxone distribution, and outreach and awareness campaigns.

HEALTH CARE AFFORDABILITY

- **Office of Health Care Affordability (OHCA).** The budget authorizes and funds the OHCA (housed within HCAI), whose goals are to improve health care affordability while promoting quality, equity, and workforce stability. Its key responsibilities are to increase transparency on costs, develop cost targets for the health care industry, enforce compliance with the cost targets, monitor and review market transactions, and establish new standards, such as for quality and equity. Full implementation will occur over several years. Providers will have the opportunity to justify cost growth above cost targets due to factors like rising labor costs and state-mandated capital expenditures.
- **Elimination of Medi-Cal Premiums.** Historically, Medi-Cal beneficiaries with incomes above certain levels were required to pay premiums, typically around $13 per person per month. The budget eliminates these premiums, effective July 2022.
- **Reduction of Medi-Cal Cost-Sharing Requirements for Affected Seniors and Persons with Disabilities.** Contingent upon a future determination by the Department of Finance that state funding can support this change, the state would reduce cost-sharing requirements for Medi-Cal beneficiaries with incomes too

high for them to qualify for cost-free Medi-Cal. This policy would take effect in January 2025.

- **CalRx Biosimilar Insulin Initiative.** The budget provides $101 million in one-time funding to develop low-cost insulin products to support the manufacturing and distribution of state-branded generic insulin, as well as the construction of a California-based manufacturing facility.

OTHER MEDI-CAL POLICIES

- **Permanent Extension of Certain Medi-Cal COVID-19 Policies.** The budget makes permanent several Medi-Cal policies that address the COVID-19 pandemic. These include expanding hospital presumptive eligibility for seniors and persons with disabilities, allowing separate billing for COVID-19 vaccine administration at FQHCs, increasing oxygen and respiratory durable medical equipment rates to 100% of Medicare rates, and maintaining the 10% rate increase for intermediate care facilities for the developmentally disabled.
- **Equity and Practice Transformation Payments.** The budget approves a multi-year $700 million initiative to support clinical infrastructure improvements aimed at improving children's preventive services, maternal and adolescent depression screening, follow-up after behavioral health-related emergency department visits, and closing racial and ethnic disparities on measures of preventive services and Cesarean rates. Incentive payments to providers will be made through Medi-Cal managed care plans. Details remain under development.
- **Forgiveness of Independent Pharmacy Recoupments.** The budget provides $143 million over two years to forgive retroactive recoupments from independent pharmacies owed due to a change in Medi-Cal's methodology for pharmacy reimbursement. Independent pharmacies include those for which no person or entity owns more than 74 pharmacies in California. This action will coincide with the end of related litigation between pharmacies and the state.
- **Extension of Nursing Facility Financing Methodology.** The state's methodology for reimbursing freestanding nursing facilities for Medi-Cal stays was set to expire in 2022 but the budget extends and makes changes to this methodology, effective January 2023 through December 2026. The updated methodology provides a 4% average annual rate increase, extends the 10% COVID-19 rate increase through 2023, establishes a new workforce and quality incentive program, and authorizes additional rate increases for facilities that meet new workforce standards.
- **Medi-Cal FQHC Alternative Payment Methodology.** The budget authorizes the implementation of a voluntary alternative payment methodology for FQHCs to encourage a move away from volume-based reimbursement. This program will be implemented no sooner than January 2024.
- **Elimination of Certain Medi-Cal Provider Payment Reductions.** Effective July 2022, the budget allocated $20 million to eliminate certain Medi-Cal fee-for-service provider payment reductions that have been in place since the Great Recession. These include, but are not limited to, rates for the following providers: nurses, alternative birthing centers, oxygen and respiratory durable medical equipment providers, portable imaging services, emergency medical air transportation, surgical clinics, and outpatient heroin detoxification services.
- **Elimination of End-of-Year Delay in Fee-for-Service Payment Processing.** Since 2007, the state has delayed Medi-Cal fee-for-service payments from the last two weeks of the state fiscal year (June) to the beginning of the following fiscal year (July), a budget maneuver that resulted in one-time state savings. The 2022-23 budget eliminates this delay in payments beginning in June 2023 at a one-time cost of $796 million, with the goal of accelerating payments to providers.

OTHER HEALTH-RELATED ISSUES

- **COVID-19 Supplemental Sick Leave Extension.** The budget extends the deadline for employees to use their existing COVID-19 supplemental paid sick leave from Sept. 30 to Dec. 31, 2022. and provides funding for nonprofit employers with fewer than 50 employees to offset some of the costs. Additionally, it allows employers to require employees to take a third test, at no cost to the employee and within 24 hours,

if an employee's second test is positive after the initial five-day isolation period. Finally, it allows employers to reject supplemental paid sick leave beyond the initial 40 hours if an employee refuses to take these tests.

- **Reproductive Health Package.** The budget includes a $225 million package of investments to promote access to reproductive health care. This includes grants for reproductive health care providers who provide uncompensated care to uninsured and underinsured individuals, supplemental payments for non-hospital community clinics that provide abortion services, investments in the reproductive health care workforce, funding for physical and electronic infrastructure improvements at facilities that provide related services, coverage of the human papillomavirus vaccine within the Family Planning, Access, Care and Treatment Program, the backfill of lost Title X family planning funding, and more.
- **Health Information Exchange (HIE) Grants.** The budget allocates $50 million over two years to support HIE adoption, as required under the California Data Exchange Framework. The grants will support the provision of technical assistance, provider onboarding to HIEs, an incentive program to encourage the adoption of electronic health record systems compatible with HIE, and other activities.
- **Infectious Disease Testing and Navigation Service Grants.** The budget allocates $15 million to the California Department of Public Health to administer a one-time grant program to support testing and navigation services for infectious diseases, including hepatitis C, HIV, and syphilis. These grants are targeted toward hospital emergency departments.
- **Climate Change and Health.** The budget includes $35 million to support local health jurisdiction planning, including the development of climate and health resiliency plans, and to track climate-sensitive diseases and health impacts. The California Department of Public Health will administer this funding.

CIVIL ACTIONS/LEGAL

MICRA reform
AB 35 (Reyes, D-San Bernardino)

Adjusts the Medical Injury Compensation Reform Act's (MICRA) cap on non-economic damages, which is currently limited to $250,000. Effective Jan. 1, 2023, this limit will be increased to $350,000 for non-death cases and $500,000 for death cases, followed by incremental increases over the next 10 years to $750,000 for non-death cases and $1 million for death cases, after which a 2% annual inflationary adjustment will apply. In addition, three separate categories of caps are created that may apply depending on the facts of each case: one cap each for health care providers, for health care institutions, and for "unaffiliated" health care providers/institutions, all as defined in the bill. No health care provider can be held liable for damages under more than one category, regardless of how the categories are applied or combined. Increases the minimum amount of the judgment required to request periodic payments to $250,000. Substantially expands the protections for benevolent gestures (expressions of sympathy, regret, etc.) and acceptance of fault relating to an injury, death, adverse patient safety event or unexpected health care outcome, making these expressions confidential, not subject to discovery or disclosure, and not admissible into evidence in any civil, administrative, regulatory, licensing, disciplinary board, or agency proceeding. Also restructures and increases the fees a plaintiff's attorney may charge.

Pajaro Valley Health Care District
SB 418 (Laird, D-Santa Cruz)

Creates the Pajaro Valley Health Care District if the relevant county board of supervisors appoints an initial board of directors. Requires the district to notify the County of Santa Cruz local agency formation commission (LAFCO) when the district, or any other entity, acquires Watsonville Community Hospital. Requires the LAFCO to order the dissolution of the district if the hospital has not been acquired by Jan. 1, 2024.

Dependents/wards of the juvenile court: medication documentation
SB 528 (Jones, R-Santee)

Requires a court order approving a request to administer psychotropic medication to a dependent or ward of the juvenile court to include the last two pages of form JV-220(A)

or JV-220 (B) and all medication sheets attached thereto.

Pajaro Valley Health Care District
SB 969 (Laird, D-Santa Cruz)

Requires the local agency formation commission (LAFCO) to develop and determine a sphere of influence for the district within one year of the district's formation and conduct a municipal service review regarding health care provision in the district by Dec. 31, 2025, and each five years thereafter.

CLINICAL

Healing arts: expedited licensure process: applicants providing abortions
AB 657 (Cooper, D-Elk Grove)

Requires the Medical Board of California, the Osteopathic Medical Board of California, the Board of Registered Nursing, and the Physician Assistant Board to expedite the licensure process of an applicant who intends to provide abortions.

Telephone medical advice services
AB 1102 (Low, D-Campbell)

Requires a telephone medical advice service to ensure that all health care professionals who provide telephone medical advice services from an out-of-state location are operating consistent with the laws governing their respective licenses. Also clarifies that a telephone medical advice service is required to comply with directions and requests for information made by the respective in-state healing arts licensing boards. Repeals the requirement that a telephone medical advice service notify the Department of Consumer Affairs within 30 days of any change of name, physical location, mailing address, or telephone number of any business, owner, partner, corporate officer, or agent for service of process in California.

Clinical labs: blood withdrawal
AB 1120 (Irwin, D-Thousand Oaks)

Allows a certified phlebotomy technician to collect blood through a peripheral venous catheter under specified conditions, including that it is performed under the general supervision of a physician using a device approved by the Food and Drug Administration.

Limited podiatric radiography permits
AB 1704 (Chen, R-Yorba Linda)

Authorizes the Department of Public Health to issue a limited podiatric radiography permit if the applicant has satisfied certain eligibility requirements, including completing a course in radiation safety and passing an exam.

Patients using cannabis
AB 1954 (Quirk, D-Hayward)

Prohibits a physician from automatically denying treatment or medication to a qualified patient based solely on a positive drug screen for THC or report of medical cannabis use without first completing a case-by-case evaluation of the patient that includes a determination that such use is medically significant to the treatment or medication. The use of medical cannabis that has been recommended by a licensed physician shall not constitute the use of an illicit substance in this evaluation. Prohibits a physician from being denied any right or privilege for administering treatment to a qualified patient pursuant to this bill and consistent with the standard of care.

Clinical laboratory testing
AB 2107 (Flora, R-Ripon)

Allows a licensed clinical genetic molecular biologist scientist to use molecular biology techniques to perform a clinical lab test to detect any disease affecting humans.

Mobile stroke units
AB 2117 (Gipson, D-Carson

Defines a "mobile stroke unit" to mean a multijurisdictional mobile facility that serves as an emergency response critical care ambulance under the direction of a local Emergency Medical Services Agency, and as a diagnostic, evaluation, and treatment unit, providing radiographic imaging, lab testing, and medical treatment under physician supervision (in-person or by telehealth).

Lead poisoning prevention: laboratory reporting
AB 2326 (Reyes, D-Grand Terrace)

Requires labs to report additional information, starting July 1, 2023, to the Department of Public Health regarding blood lead analyses, unless the ordering provider cannot or will not provide the requested information.

Occupational therapy
AB 2671 (Berman, D-Menlo Pari)

Increases the limit on the total

number of occupational therapy assistants to 3 times the number of occupational therapists regularly employed by a facility at any one time.

Moratorium on new hospice licenses
AB 2673 (Irwin, D-Thousand Oaks)

Extends the existing moratorium on the Department of Public Health to issue new hospice licenses to end on Jan. 1, 2027, or two years after the California State Auditor publishes a report on hospice licensure, whichever is earlier. Enacts numerous recommendations from the Auditor's report on hospice licensure.

Nursing
AB 2684 (Berman, D-Menlo Park)

The Board of Registered Nursing (BRN) concluded its sunset review process and has been renewed until Jan. 1, 2027. The bill makes many minor changes to the operations of the BRN.

Speech-language pathologists, audiologists, and hearing aid dispensers
AB 2686 (Berman, D-Menlo Park)

Extends the operation of the Speech-Language Pathology & Audiology & Hearing Aid Dispenser Board. Provides additional authorities to the board.

General acute care hospitals: drug screening
AB 864 (Melendez, R-Lake Elsinore)

Requires a general acute care hospital to test for fentanyl each time it conducts a urine drug screen to assist in diagnosing a patient's condition.

Medicinal cannabis
SB 988 (Hueso, D-San Diego)

Amends and clarifies the Compassionate Access to Medical Cannabis Act (Ryan's Law) enacted in 2021, which requires hospitals and other specified health care facilities to allow a terminally ill patient to use medicinal cannabis in the facility, subject to certain restrictions. Repeals the requirement that these facilities comply with drug and medication requirements applicable to Schedule II, III, and IV drugs when permitting patient use of medicinal cannabis. It also revises the requirements for how a health facility permits patient use of medicinal cannabis, including (1) requiring the patient or primary caregiver to be responsible for acquiring, retrieving, administering, and removing the medicinal cannabis; (2) requiring that it be stored securely in a locked container in the patient's room, another designated area, or with the patient's primary caregiver; and (3) prohibiting health care professionals and facility staff from administering medicinal cannabis or retrieving it from storage.

Vocational nursing: direction of naturopathic doctor
SB 994 (Jones, R-Santee)

Allows a licensed vocational nurse to practice under the direction of a naturopathic doctor. A written supervision protocol is required.

Clinical laboratory professionals
SB 1267 (Pan, D-Sacramento)

Adds geneticists and reproductive biologists to the types of clinical laboratory personnel that are licensed and regulated and defines their subspecialties and duties.

Nurses: abortion and practice standards
SB 1375 (Atkins, D-San Diego)

Revises requirements related to the performance of abortions by aspiration techniques by nurse practitioners and nurse-midwives.

Blood banks: collection
SB 1475 (Glazer, D-Orinda)

Authorizes a blood bank to collect blood when a physician is not physically present if the employee in charge is a registered nurse who is physically present or available via synchronous telehealth. The blood bank's medical director and medical advisory committee must approve and must make certain reports to the Department of Public Health. Sunsets Jan. 1, 2028, unless extended by the legislature.

HEALTH FACILITIES

Chemical dependency recovery hospitals
AB 2096 (Mullin, D-South San Francisco)

Revises licensing requirements for chemical dependency recovery hospitals. Permits chemical dependency recovery services to be provided in a freestanding facility, within a hospital building that provides only chemical dependency recovery services, or within a distinct part. Allows these services to be provided in a hospital building that has been removed from general acute care use.

Children's psychiatric residential facilities
AB 2317 (Ramos, D-Highland)

Requires the Department of Health Care Services to license and regulate children's psychiatric residential facilities, defined as a licensed residential facility operated by a public agency or private nonprofit organization to provide inpatient psychiatric services, as prescribed under Medicaid regulations, to individuals under 21 years of age.

Building standards: fire resistance based on occupancy risk categories
AB 2322 (Wood, D-Santa Rosa)

Requires the State Fire Marshal — prior to the next edition of the California Building Standards Code adopted after Jan. 1, 2023 — to propose to the Building Standards Commission, mandatory building standards for fire resistance based on occupancy risk categories in California fire severity zones. These new building standards will apply to nonresidential, critical infrastructure buildings, including hospitals.

HEALTH PLAN AND INSURER REGULATION

Lobbying the Insurance Commissioner or the Director of the Department of Managed health Care
AB 1783 (Levine, D-Marin County)

The Political Reform act imposes requirements on lobbyists and lobbyist employers involved in administrative actions. AB 1783 expands the definition of "administrative action" to include any decision or approval of transactions by the Insurance Commissioner or the Director of the Department of Managed Health Care.

Telehealth: dental care
AB 1982 (Santiago, D-Los Angeles)

Requires health care service plans and health insurers that cover dental services via telehealth through a third-party corporate telehealth provider to disclose to patients the impact of these visits on benefit limitations, including frequency limitations and the patient's annual maximum. Requires plans and insurers to submit specified information to the Department of Managed Health Care or Department of Insurance.

Health care coverage: dependent adults
AB 2127 (Santiago, D-Los Angeles)

Requires a health plan, health insurer, solicitor, or agent to provide at the time of solicitation and on the application for dependent coverage for a parent or stepparent who is a qualifying relative, information about the Health Insurance Counseling and Advocacy Program (HICAP).

Care coordination, follow-up appointments
AB 2242 (Santiago, D-Los Angeles)

Requires health care payers to provide patients released from involuntary psychiatric holds with a care coordination plan and first follow-up appointment. Additionally, requires the state Department of Health Care Services to convene a stakeholder process to develop a model care coordination plan to be used by health care payers in the future.

Prescription drug information
AB 2352 (Nazarian, D-Van Nuys)

Requires health plans and insurers to make specified prescription drug information available upon the request of an enrollee or insured or their prescribing provider. This includes the enrollee or insured's eligibility for the prescription drug, the up-to-date drug formulary, and cost-sharing and applicable utilization management requirements for the prescription drug and other formulary alternatives.

California Health Benefit Exchange: financial assistance
AB 2530 (Wood, D-Santa Rosa)

Requires the California Health Benefit Exchange, beginning July 1, 2023, to provide financial assistance to Californians who lose employer-provided health care coverage due to a labor dispute.

Health care coverage: mental health and substance use disorder providers
AB 2581 (Salas, D-Bakersfield)

Requires health care service plans and disability insurers that provide coverage for mental health and substance use disorders to assess and verify the credentials of providers of these services within 60 days of receipt of the provider's application.

Long-term care insurance
AB 2604 (Calderon, D-Whittier)

Requires the California Partnership for Long-Term Care Program to provide lower-cost inflation adjustment options.

Health care coverage: timely access to care
SB 225 (Wiener, D- San Francisco)

Requires health care service plans and health insurers to incorporate timely access to care standards into their quality assurance systems. Authorizes the Departments of Managed Health Care and Insurance to review and adopt standards for timely access, and take compliance or disciplinary actions, including assessing administrative penalties, for violations. Does not apply to Medi-Cal managed care plans, except as specified.

Abortion cost-sharing
SB 245 (Gonzalez, D-Long Beach)

Prohibits health plans and insurers from imposing cost-sharing requirements such as deductibles, copayments, and coinsurance, on abortions and abortion-related services. The bill also prohibits the imposition of utilization management and review on abortions and related services. The bill's requirements apply to Medi-Cal managed care plans as well as health plans and delegated provider groups.

Contraceptive Equity Act of 2022
SB 523 (Leyva, D-Chino)

Makes various changes to expand coverage of contraceptives by health care service plans and health insurers for policies issued, amended, renewed, or delivered on and after Jan. 1, 2024. Requires plans and policies offered by public or private institutions of higher learning or by CalPERS to comply with these contraceptive coverage requirements. Prohibits, with certain exceptions, the imposition of a deductible, coinsurance, copayment, or any other cost-sharing requirement on vasectomies. Prohibits discrimination based on reproductive health decision-making by employers, labor organizations, apprenticeships and training programs, and licensing boards.

Health care coverage outreach
SB 644 (Leva, D-Chino)

Requires the California Health Benefit Exchange to obtain contact information for each new applicant for unemployment compensation, disability, and family leave, and to inform those individuals of the availability of health care coverage through the Exchange.

Health plan civil penalties
SB 858 (Wiener, D-San Francisco)

Increases the base amount of a civil penalty levied on a health plan found to have violated the Knox-Keene Act from up to $2,500 per violation to up to $25,000 per violation. Beginning in January 2028, the maximum penalty amount will be adjusted every five years by the average rate of change in premium rates in the individual and small group markets.

Emergency flexibilities
SB 979 (Dodd, D-Napa)

Gives state health plan and insurance regulators the authority to require health plans and insurers to take additional steps to assist their members whose health is affected by a disaster even if their members are not displaced, as required under current law. This bill is intended to enable state regulators to hold health plans and insurers accountable for more timely and flexible service authorizations and referrals, ensure access to out-of-network providers when in-network providers are unavailable, extend claim-filing deadlines, and enable other changes to existing state rules.

Employee training in trans-inclusive health care
SB 923 (Wiener, D- San Francisco)

Requires staff of Medi-Cal managed care plans, PACE organizations, health care service plans, health insurers, and delegated entities to complete training in trans-inclusive health care.

Cancer care
SB 987 (Portantino, D-La Canada Flintridge)

Requires Medi-Cal managed care plans to make a good faith effort to contract with at least one National Cancer Institute (NCI)-designated comprehensive cancer center, a site affiliated with the NCI Community Oncology Research Program, or qualifying academic cancer center within each county in which it operates, and authorize any eligible enrollee to request a referral to any of these centers. Requires Medi-Cal managed care plans to notify enrollees of the right to request a referral.

Workers' compensation: social workers
SB 1002 (Portantino, D-La Canada Flintridge)

Allows an employer workers' compensation insurer or self-insured employer to provide employees with access to the services of a licensed clinical social worker.

Maternal mental health program
SB 1207 (Portantino, D-La Canada Flintridge)

Extends the deadline to July 1, 2023, for health plans and insurers to develop a maternal mental health program. Revises the requirements of the programs.

COVID-19 therapeutics coverage
SB 1473 (Pan, D-Sacramento)

Requires health plans and insurers to cover, without cost-sharing or utilization management requirements, COVID-19 therapeutics that are approved or granted emergency use authorization by the Food and Drug Administration. Requires reimbursement for COVID-19 therapeutics at negotiated rates for in-network providers and at reasonable rates for out-of-network providers. Beginning six months after the federal public health emergency expires, permits health plans and insurers to no longer cover cost-sharing for COVID-19 diagnostic, screening, and related services when delivered by an out-of-network provider, except as otherwise required by law. Makes consistent the annual open enrollment periods for individual health benefit plans offered through and outside of Covered California.

LABOR AND EMPLOYMENT

COVID-19 relief: supplemental paid sick leave
AB 152 (Assembly Committee on Budget)

Extends to Dec. 31, 2022, the existing COVID-19 supplemental paid sick leave provisions that were set to expire on Sept. 30. The bill also specifies that the employer has no obligation to provide additional COVID-19 supplemental paid sick leave for employees who refuse to submit to COVID-19 tests permitted under existing law.

Family leave
AB 1041 (Wicks, D-Oakland)

Allows employees to take family leave for any "designated person," not just family members as currently defined. Employers may limit an employee to one designated person per 12-month period.

Workers' compensation: COVID-19 infection
AB 1751 (Daly, D-Anaheim)

Extends, until Jan. 1, 2024, current law presuming that specified workers' compensation claims relating to COVID-19 are work-related.

Bereavement leave
AB 1949 (Low, D-Campbell)

Requires employers to give eligible employees up to 5 days bereavement leave upon the death of a family member. Leave, which may be unpaid, must be taken within 3 months after death.

Emergency medical services training
AB 2130 (Cunningham, R-San Luis Obispo County)

Requires, starting July 1, 2024, emergency medical technicians and paramedics to complete at least 20 minutes of training on human trafficking for initial licensure.

Discrimination in employment: use of cannabis
AB 2188 (Quirk, D-Hayward)

Prohibits, on and after Jan. 1, 2024, an employer from discriminating against a person in hiring, termination, or any term or condition of employment based on (1) a screening test showing the presence of non-psychoactive cannabis metabolites or (2) the person's off-the-job and away from the workplace use of cannabis, with some exceptions. Employers can continue to make employment decisions based on scientifically valid preemployment drug screening conducted through methods that do not screen for non-psychoactive cannabis metabolites, such as tests showing THC, which may indicate an individual is impaired.

Optometry
AB 2574 (Salas, D-Bakersfield)

Reinstates two provisions that were inadvertently dropped out of state law when AB 407 was enacted last year. Reinstates the ability of an optometrist to (1) be a lab director for CLIA waived testing and (2) stabilize a patient with an acute attack of angle closure glaucoma.

COVID-19: exposure
AB 2693 (Reyes, D-San Bernardino)

Allows Cal/OSHA to prohibit the performance of an operation or process, or entry into a place of employment, when this would expose workers to the risk of COVID-19 infection so as to constitute an imminent hazard to employees. Sunsets on Jan. 1, 2024. Also permits employers to comply with the COVID-19 notice provisions by posting a general COVID-19

exposure notice where other notices concerning workplace rules and regulations are posted, as specified.

COVID-19 supplemental paid sick leave

SB 114 (Committee on budget and fiscal review)

Extended, until Sept. 30, 2022, specified COVID-19 supplemental paid sick leave provisions that expired on Sept. 30, 2021.

Hospital and Nursing Home Worker Retention Pay

SB 184 (Senate Committee on Budget)

Creates the Hospital and Skilled Nursing Facility COVID-19 Worker Retention Pay Program, which provides up to $1,500 for specified full-time employees.

Retaliation

SB 1044 (Durazo, D-Los Angeles)

Prohibits an employer from retaliating against workers for leaving work, or refusing to come to work, if the employee has a reasonable belief the workplace is unsafe during an emergency (which does not include a pandemic). Prohibits employers from preventing employees from using their cellphones to get help or determine if they're unsafe. (This bill was enacted due to an incident in Illinois where some Amazon warehouse workers were required to stay on the job during a tornado, resulting in two employee deaths.)

Workers' compensation: timeline for objection to claim

SB 1127 (Atkins, D-San Diego)

Requires employers to object to a workers' compensation claim within 75 days or it is presumed compensable. May then be rebutted only by evidence discovered after the 75 days. Previously, the relevant time period was 90 days.

Submission of pay data to the state

SB 1162 (Limon, D-Santa Barbara)

Requires private employers with 100 or more employees to submit a pay report to the Civil Rights Department even if they are not required to file an annual Employer Information Report (EEO-1) under federal law. Must be filed on or before the second Wednesday of May of each year, starting in 2023.

Meal and rest periods: hospital employees

SB 1334 (Bradford, D-Gardena)

Existing law requires private sector employers to provide specified meal and rest periods to employees who provide direct patient care or support direct patient care. This bill applies those laws to public sector hospitals, clinics, and public health settings as well.

MEDI-CAL

Medi-Cal: Specialty mental health services: foster children

AB 1051 (Bennett, D-Ventura)

Current law requires each local mental health plan to ensure access to outpatient specialty mental health services, as required by the EPSDT program standards, for youth in foster care who have been placed outside their county of adjudication. AB 1051 requires, commencing July 1, 2023, in the case of placement of foster children in short-term residential therapeutic programs, community treatment facilities, or group homes, or in the case of admission of foster children to children's crisis residential programs, the presumptive transfer provisions to apply only if certain circumstances exist. These circumstances include (1) that the case plan for the foster child specifies that the child will transition to a less restrictive placement in the same county as the facility in which the child has been placed, or (2) that the placing agency determines that the child will be negatively impacted if responsibility for providing or arranging for specialty mental health services is not transferred to the same county as the facility in which the child has been placed.

Violence prevention services

AB 1929 (Gabriel, D-Encino)

Adds violence prevention services as a new covered benefit under Medi-Cal. The new benefit would be subject to medical necessity and utilization controls and would be implemented only to the extent the state receives federal approval. Violence prevention services are defined as "evidence-based, trauma-informed, and culturally responsive preventive services provided to reduce the incidence of violent injury or reinjury, trauma, and related harms and promote trauma recovery, stabilization, and improved health outcomes." Following federal approval, the state will be required to implement the new covered benefit through the issuance of All-County Letters, All Plan Letters, and plan or provider bulletins.

Community health workers, promotoras benefits
AB 2697 (Aguiar-Curry, D-Davis)

Requires the state to implement a community health worker (CHW) and promotoras benefit under the Medi-Cal program, subject to federal approval. CHW/promotoras services are preventive services that provide health education and navigation for specified target populations. Additionally, Medi-Cal managed care plans are required to engage in outreach and education efforts to providers about the benefit and conduct an assessment every three years on the capacity of CHW and promotoras. The state is also required to publish an analysis of the CHW/promotoras benefit on its website.

Medi-Cal alternate health care service plan
AB 2724 (Arambula, D-Fresno)

Authorizes the Department of Health Care Services to directly contract with an alternate health care service plan, as defined, to serve as a Medi-Cal managed care plan in designated geographic regions of the state. It appears that only Kaiser Permanente fits the definition of an alternative health care service plan.

Medi-Cal: short term community transitions program
SB 281 (Dodd, D-Napa)

Extends the sunset for an additional three years for a temporary, state-only California Community Transitions program based on the Money Follows the Person Rebalancing Demonstration to provide services for individuals who have resided less than 60 consecutive days in an inpatient facility to aid in the transition to a community setting. Requires the Department of Health Care Services to extend new enrollment until Jan. 1, 2026, and extend providing services until Jan. 1, 2027.

Medi-Cal managed care plans: mental health benefits
SB 1019 (Gonzalez, D-Long Beach)

Requires Medi-Cal managed care plans, no later than Jan. 1, 2025, to conduct annual outreach and education for enrollees and primary care providers about the mental health benefits they cover.

MEDICAL STAFF

Patient notice of open payments database
AB 1278 (Nazarian, D-Van Nuys)

Requires a physician to provide multiple notices of the federal Open Payments database, where applicable manufacturers of drugs, devices, and biological or medical supplies annually report certain payments and other transfers of value to covered recipients like physicians. Notices must be provided to patients at the initial office visit; be placed in each location where the licensee practices; and, beginning Jan. 1, 2024, posted on the website used for the physician's practice. If the physician is employed by a health care employer, the employer must comply with these posting requirements. These requirements do not apply to a physician working in a hospital emergency room.

Professional licensure: registered sex offenders
AB 1636 (Weber, Akilah, D-San Diego)

Authorizes a state licensing board to deny a license based on formal discipline that occurred earlier than 7 years preceding the date of application if the formal discipline was based on conduct that, if committed in this state by a licensed physician and surgeon, would have constituted an act of sexual abuse, misconduct, or relations with a patient or sexual exploitation, as specified. Expands the circumstances under which the Medical Board of California will deny a license to a sex offender.

Unprofessional conduct: COVID-19
AB 2098 (Low, D-Cupertino)

With respect to COVID-19, makes it unprofessional conduct for a physician to "disseminate" "misinformation" or "disinformation." This includes false or misleading information regarding the nature and risks of the virus; its prevention and treatment; and the development, safety, and effectiveness of COVID-19 vaccines.

Special faculty permits
AB 2178 (Bloom, D-Santa Monica)

Revises the definition of "academic medical center" for purposes of obtaining a special faculty permit from the Medical Board of California. The revision more accurately reflects the terms used by academic medical centers but does not change the requirements and standards for the institutions.

Licensee discipline: abortion
AB 2626 (Calderon, D-Whittier)

Prohibits the Medical Board of California and the Osteopathic Medical Board of California from suspending or revoking a physician's certificate solely for performing an abortion if it is performed in accordance with the provisions of the Medical Practice Act and the Reproductive Privacy Act.

MENTAL/BEHAVIORAL HEALTH

General acute care hospitals: suicide screening
AB 1394 (Irwin, D-Thousand Oaks)

Requires general acute care hospitals to have suicide prevention policies, procedures, and routine screening for patients ages 12 and older, by Jan. 1, 2025.

Involuntary commitment
AB 2275 (Wood, D-Santa Rosa)

Specifies that the start of a 72-hour involuntary psychiatric hold begins when a person is first detained. It also conforms California statutes to case law entitling individuals to a certification hearing if they are not released from involuntary detention within seven days.

Advance health care directives: mental health treatment
AB 2288 (Choi, R-Irvine)

Clarifies that an agent appointed in an advance health care directive may make decisions regarding a patient's mental health conditions. Modifies the statutory advance health care directive form accordingly.

Substance use disorder counselors
AB 2473 (Nazarian, D-North Hollywood)

Requires the Department of Health Care Services (DHCS) to determine the required core competencies for registered and certified substance use disorder counselors. DHCS may not implement the requirements before July 1, 2025. Counselors in good standing are exempted from the requirements if specified criteria are met.

Psychology supervision
AB 2754 (Bauer-Kahan, D-Orinda)

Authorizes the supervision of an applicant for licensure as a psychologist or registered psychological associate to be provided in-person or via synchronous audiovisual means.

California Ethical Treatment for Persons with Substance Use Disorder Act
SB 349 (Umberg, D-Santa Ana)

Creates the California Ethical Treatment for Persons with Substance Use Disorder Act to protect substance use disorder treatment clients and their families. Imposes requirements and proscribes unlawful acts related to marketing and advertising by treatment providers (prohibits treatment providers from making false or misleading statements in marketing or advertising). Requires treatment providers to adopt a client bill of rights and to maintain records of referrals to or from a recovery residence.

Psychology: unprofessional conduct: sexual acts
SB 401 (Pan, D-Sacramento)

Revises the law under which specified sexual acts with a client or former client constitute unprofessional conduct for a psychologist.

Mental health services data collection
SB 929 (Eggman, D-Stockton)

Requires the Department of Health Care Services to collect and publish information relating to involuntarily detained mental health patients, including numbers, outcomes, detention time lengths, and demographics.

Assisted outpatient treatment
SB 1035 (Eggman, D-Stockton)

Allows the court to conduct status hearings with a patient who is subject to an assisted outpatient treatment (AOT) order to receive information regarding progress and adherence to the treatment plan, including medication adherence. Requires the AOT program director to include specified information when filling an affidavit affirming the person continues to meet the criteria for AOT.

Advertisement by substance abuse and mental health service providers
SB 1165 (Bates, R-Laguna Niguel)

Prohibits an operator of a licensed alcoholism or drug abuse recovery facility, a certified alcohol or other drug program, or a licensed psychiatric or mental health facility from making false or misleading statements about services offered.

Involuntary commitment: intensive treatment
SB 1227 (Eggman, D-Stockton)

Permits an additional intensive treatment period of up to 30 days if, after 15 days of the initial 30-day period of intensive treatment, but at least 7 days before expiration of the 30 days, the professional staff of the facility treating the person determine that the individual requires additional treatment. Permits the professional staff to file a petition in the superior court for the county in which the facility is located to seek approval for up to an additional 30 days of intensive treatment.

CARE Court Program
SB 1338 (Umberg, D-Santa Ana)

Enacts Gov. Newsom's Community Assistance, Recovery, and Empowerment (CARE) Court program, which will initially be implemented in seven counties: Glenn, Orange, Riverside, San Diego, Stanislaus, Tuolumne, and the City and County of San Francisco. It also authorizes a variety of individuals and agencies, including hospitals, to petition a civil court to begin CARE Court proceedings to order counties to evaluate and treat adults with a psychotic disorder who are unlikely to survive safely in the community and are substantially deteriorating.

Psychological testing technicians
SB 1428 (Archuleta, D-Pico Rivera)

Requires, by Jan. 1, 2024, an individual performing psychological or neuropsychological testing to register as a psychological testing technician with the Board of Psychology. Allows, psychological testing technicians to administer and score standardized objective psychological and neuropsychological tests and observe and describe clients' test behavior and responses.

PATIENT RIGHTS

Child abuse reporting
AB 2085 (Holden, D-Pasadena)

Limits the definition of "general neglect" for purposes of mandated reporting under the Child Abuse and Neglect Reporting Act to include only circumstances where the child is at substantial risk of suffering serious physical harm or illness. Specifies that "general neglect" for this purpose "does not include a parent's economic disadvantage."

Reproductive health care
AB 2134 (Weber, D-San Diego)

Establishes the California Abortion and Reproductive Equity Act and the California Reproductive Health Equity Program within the Department of Health Care Access and Information. These are designed to ensure abortion and contraception services are affordable and accessible for all patients and to provide financial support for safety-net providers (including Medi-Cal providers) of these services. Requires a health care service plan that provides health coverage to employees of a religious employer that does not include coverage and benefits for both abortion and contraception to provide an enrollee or insured with written information that abortion and contraception benefits and services may be available at no cost through the program.

Health care decisions: decision-makers and surrogates
AB 2338 (Gipson, D-Carson)

Codifies existing state law about who may make health care decisions for adult patients who lack the capacity to make their own decisions. The bill also authorizes patients to verbally designate a surrogate decision-maker during a particular hospitalization by informing a designee of the health care facility caring for the patient, such as an admissions clerk.

Grants for reproductive health education providers
AB 2586 (Garcia, Cristina, D-Bell Gardens)

Establishes the California Reproductive Justice and Freedom fund to award grants to organizations that provide comprehensive reproductive and sexual health education.

Reproductive freedom
State Constitutional Amendment 10 (Atkins, D-San Diego)

Proposes an amendment to the state Constitution to prohibit the state from denying or interfering with an individual's reproductive freedom in their most intimate decisions, which includes their fundamental right to choose to have an abortion and to choose or refuse contraceptives. This proposal appeared on California's November ballot and was passed by the voters.

PHARMACY

Insulin manufacturing
SB 838 (Pan, D-Sacramento)

Existing law – the California Affordable Drug Manufacturing Act of 2020 – requires the California Health and Human Services Agency to a contract with a pharmaceutical manufacturer to create a California-branded label for generic drugs. This bill makes it easier for the state-pharmaceutical manufacturer partnership to produce at least one form of insulin that will be made available at production and dispensing costs while guaranteeing priority access for the state. It also requires the state to consider the volume of each generic prescription drug utilization over a multi-year period to help drive down the costs of the drug.

Electronic Prescriptions
SB 852 (Wood, D-Santa Rosa)

Prohibits a pharmacy, pharmacist, or other practitioner authorized to dispense or furnish a prescription from refusing to dispense or furnish an electronic prescription solely because the prescription was not submitted via, or is not compatible with, their proprietary software. Establishes additional exceptions to the requirement that health care practitioners issue a prescription as an electronic data transmission prescription, including for a prescriber who registers with the California State Board of Pharmacy and states that they issue 100 or fewer prescriptions per year.

Mobile pharmacy units
SB 872 (Dodd, D-Napa)

Authorizes a county, city and county, or special hospital authority to operate a mobile unit as an extension of a pharmacy license it holds to provide services to homeless patients.

Furnishing opioid antagonists
SB 1259 (Laird, D-Santa Cruz)

Authorizes a pharmacist to furnish an opioid antagonist approved by the federal Food and Drug Administration, instead of only naloxone hydrochloride, subject to certain requirements, including completing continuing education (CE) on the use of opioid antagonists.

Surplus medication collection and distribution
SB 1346 (Becker, D-Menlo Park)

Makes various changes to the requirements for a voluntary drug repository and distribution program that distributes surplus medications to medically indigent patients.

PRIVACY AND PERSONAL INFORMATION

Immunization registry
AB 1797 (Weber, D- San Diego)

Requires (instead of permits, which is existing law) a health care provider to disclose immunization information and tuberculosis test results to local health departments operating an immunization registry and to the California Department of Public Health. This bill also requires providers to report each patient's race and ethnicity.

Mental health digital services
AB 2089 (Bauer-Kahan, D-Orinda)

Subjects mental health application information to the Confidentiality of Medical Information Act.

Disclosure of information: reproductive health and foreign penal civil actions
AB 2091 (Bonta, D-Alameda)

Prohibits health care providers and employers from releasing medical information about a person seeking or obtaining an abortion in response to a subpoena or request if that subpoena or request is based on either another state's laws that interfere with a person's abortion rights or a foreign (out of state) penal civil action.

Birth registration
AB 2176 (Wood, D-Santa Rosa)

Extends the time, from 10 days to 21 days, by which live births are required to be registered with the local registrar. This bill is intended to accommodate the traditional practices of certain cultures, such as 10-day ceremonies and naming ceremonies.

Forensic examinations: domestic violence
AB 2185 (Weber, D-San Diego)

Requires a health facility that performs domestic violence evidentiary examinations to maintain evidentiary exam reports in a way that facilitates their release as required or authorized by law, maintains their confidentiality, and prevents their destruction if the evidentiary exam program closes. The bill also gives patients undergoing a domestic violence evidentiary exam the right to have a social worker, victim advocate, or support person of their choosing present – if available – during the exam. The bill requires that costs associated with the evidentiary

examination of a domestic violence victim be separate from costs of diagnosis and treatment of any injury sustained, and that costs for the evidentiary exam not be charged to the victim. Bills for evidentiary exams must be submitted to the California Office of Emergency Services (OES), which will establish a flat reimbursement rate. Cal OES is required to establish a 60-day reimbursement process.

Reporting fetal deaths to coroner
AB 2223 (Wicks, D-Oakland)

Repeals existing law that requires health care providers to notify the coroner of unattended fetal deaths and deaths related to a known or suspected self-induced or criminal abortion.

Incarcerated persons: health records
AB 2526 (Cooper, D-Elk Grove)

Requires county agencies (such as county hospitals and county jails) caring for inmates to transfer mental health records when an inmate is transferred between the California Department of Corrections and Rehabilitation, the Department of State Hospitals, and county agencies. The records must be transferred within seven days.

Gender-affirming health care
SB 107 (Wiener, D-San Francisco)

Prohibits health care providers from releasing medical information about a child who received gender-affirming care or gender-affirming mental health care in response to a civil or criminal action (including an out-of-state subpoena) based on another state's law that bans gender-affirming health care or gender-affirming mental health care for minors.

Address confidentiality: public entity employees and contractors
SB 1131 (Newman, D-Fullerton)

Expands the public record address confidentiality (Safe at Home Program) for reproductive health care workers to include harassment as a basis to apply to the program. The bill also allows an applicant to submit a certified statement that they qualify for the program, instead of requiring the reproductive health care services facility to submit a statement.

Confidentiality of Medical Information Act: school-linked services coordinators
SB 1184 (Cortese, D-San Jose)

Authorizes health care providers to disclose patient-identifiable information to a school-linked services coordinator if the patient has signed a HIPAA-compliant authorization. A school-linked services coordinator is defined as an individual located on a school campus or under contract by a county behavioral health provider agency who holds certain credentials, including a marriage and family therapist, educational psychologist, or professional clinical counselor.

Health information
SB 1419 (Becker, D-Menlo Park)

Clarifies that the law requiring health care professionals to discuss certain laboratory test results with patients prior to posting the test results online applies only to a new diagnosis of a malignancy, HIV positivity, hepatitis, or substance abuse. The bill also expands this law to imaging scans and reports. The bill restates existing law that parents may not have access to a minor's medical records related to medical services for which the minor is authorized by law to give consent, unless the minor lacks the capacity to make health care decisions because of intellectual disability, physical impairment, or other reason and the parent is acting as the surrogate decisionmaker. The bill also requires, commencing Jan. 1, 2024, health care service plans and health insurers to establish and maintain several APIs, as described by the federal regulations, for the benefit of enrollees, insureds, and contracted providers.

RURAL

Federally qualified health centers and rural health clinics: visits
SB 966 (Limón, D-Santa Barbara)

Requires the state Department of Health Care Services to seek any necessary federal approvals and issue appropriate guidance to allow a federally qualified health center (FQHC) or rural health clinic to bill, under a supervising licensed behavioral health practitioner, for an encounter between an FQHC or RHC patient and an associate clinical social worker or associate marriage and family therapist when certain requirements are met. This includes that the visit is billed under the supervising licensed behavioral health practitioner of the FQHC or rural health clinic.

SEISMIC

Annual seismic compliance update
AB 1882 (R. Rivas, D-Salinas)

Requires hospitals that have not yet met the 2030 seismic requirements to provide an annual status update on their seismic compliance to their local governments, labor unions, hospital board of directors, and certain state departments by Jan. 1, 2024. In addition, requires these hospitals to post a notice, to be provided by the Department of Health Care Access and Information (HCAI) by July 1, 2023, in the lobbies and waiting areas of hospital buildings that have not yet met the 2030 seismic requirements by Jan. 1, 2024. It also requires these hospitals to annually include information regarding the building's expected earthquake performance in emergency training, response, and recovery plans and capital outlay plans by July 1, 2023.

Seismic compliance: Pacifica Hospital of the Valley
AB 2404 (Rivas, Luz, D-Arleta)

Authorizes the Department of Health Care Access and Information to waive Seismic Safety Act requirements for Pacifica Hospital of the Valley if the hospital submits a plan that proposes compliance by Jan. 1, 2025, HCAI accepts the plan as being feasible, and the hospital reports to HCAI on its progress to timely complete the plan.

SKILLED-NURSING AND LONG-TERM CARE FACILITIES

Resident Notification
AB 895 (Holden, D-Pasadena)

Requires a skilled nursing facility or an intermediate care facility to provide a prospective resident or their representative, before or at the time of admission, a written notice that includes information about the local long-term care ombudsman. Also requires an admission agreement for a residential care facility for the elderly to include a notice with similar information. Additionally requires a facility's grievance form to include contact information for the local long-term care ombudsman and the State Department of Public Health, and instructions on how to file a grievance with both entities.

Freestanding skilled nursing facility licensure
AB 1502 (Muratsuchi, D-Torrance)

Enacts the Skilled Nursing Facility Ownership and Management Reform Act of 2022, which establishes suitability standards for persons and entities seeking to acquire, operate, or manage skilled nursing facilities (SNFs) in California. Directs the Department of Public Health to screen all persons and entities seeking licenses to acquire, operate, or manage SNFs. Requires owners and operators, including nursing home chains, to obtain prior approval before acquiring, operating, or managing a SNF. Prohibits the use of interim or longer-term management agreements to circumvent state licensure requirements. Requires the Department of Public Health to make a determination within 120 days of an applicant's submission of a complete application for any type of change to the SNF license.

Long-Term Care Ombudsman: facility access
AB 1855 (Nazarian, D-Van Nuys)

Prohibits a skilled-nursing facility or residential care facility from denying entry to a representative of the State Office of the Long-Term Care Ombudsman acting in their official capacity, except as specified. Authorizes a facility — during a state of emergency, health emergency, or local health emergency — to require a representative of the office entering the facility to adhere to infection control protocols for the duration of their visit that are no more stringent than those required for facility staff.

Skilled nursing facility inspections
AB 1907 (Bauer-Kahan, D-Orinda)

Extends the maximum period between inspections of skilled nursing facilities from two years to 30 months.

Dental services: long-term health care facilities
AB 2145 (Davies, R-Laguna Niguel)

Allows a dental hygienist in alternative practice to serve long term care facility residents.

Skilled nursing facilities: backup power source
AB 2511 (Irwin, D-Thousand Oaks)

Requires, by Jan. 1, 2024, a skilled nursing facility to have an alternative source of power that will last at least 96 hours during any time of power outage.

TELEMEDICINE

Telehealth

AB 32 (Aguiar-Curry, D-Davis)

Permits a health care provider, a federally qualified health center (FQHC) or a rural health clinic (RHC) to establish a new patient relationship using an audio-only synchronous interaction (for example, a telephone call) when (1) the visit is related to sensitive services (behavioral health, sexual and reproductive health, substance use disorder, gender affirming care, and intimate partner violence) or (2) the patient requests an audio-only modality or attests they do not have access to video. The Department of Health Care Services (DHCS) may impose requirements in these circumstances, and the bill implements these changes only to the extent necessary federal approvals are obtained and federal financial participation is available. Authorizes DHCS, in making exceptions to the requirement that health care providers offer both audio and video, to take into consideration the availability of broadband access based on speed standards set by the Federal Communications Commission.

ABOUT THE AUTHOR

Lois Richardson is vice president and legal counsel at the California Hospital Association. She advises CHA staff on proposed legislation and regulations that impact hospitals, develops public policy positions and strategy, and advocates for hospitals before legislative and regulatory bodies. Lois is also responsible for developing, writing, and updating CHA legal publications on topics such as hospital licensing and certification, patient consent, health information privacy, and mental health. Lois has served as the Executive Director of the California Society for Healthcare Attorneys since 2000.

CALIFORNIA'S HEALTH CARE QUALITY AND AFFORDABILITY ACT

by **Katrina Pagonis**
Hooper, Lundy & Bookman, P.C.

Katrina Pagonis is chair of the firm's regulatory department and a nationally recognized expert on implementation of the Affordable Care Act's market reforms, including the federal regulation of government-sponsored and private managed care plans and the establishment and operation of Health Insurance Exchanges ("Marketplaces") like Covered California. Katrina regularly advises clients on the impact of health care reform, as well as emerging health care reform proposals (from repeal-and-replace to single payer) at the state and national levels. She also provides regulatory and strategic advice to health care providers concerning managed care issues more generally, including out-of-network reimbursement, network configuration (narrow and tiered networks), reference pricing and cost-sharing limits, managed care contracting, and enrollment assistance activities.

California's newly established Office of Health Care Affordability[1] ("OHCA") is charged with analyzing cost trends and spending drivers in the health care market and creating a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers. Critically, the California Health Care Quality and Affordability Act[2] (the "Act") requires OHCA to ***enforce cost targets*** set by the Health Care Affordability Board (the "Board") and ***review certain transactions*** based on their likely impacts on the health care market. The creation of OHCA responds to legislative findings that "affordability has reached a crisis point as health care costs continue to grow" and that escalating costs are being "driven primarily by high prices and the underlying factors or market conditions that drive prices," including consolidation and market failures.[3] Health care entities subject to the Act include Knox-Keene plans, insurers, Medi-Cal managed care plans, third party administrators, and other payers; fully integrated health systems; hospitals and other health facilities; ambulatory surgical centers ("ASCs"); and certain clinics, physician organizations, clinical laboratories, and imaging facilities.

This article addresses (1) the structure and roles of OHCA and the Board; (2) the establishment of, adjustment of, and reporting on health care cost targets, including sector- and entity-specific targets and provider exemptions; (3) the enforcement of cost targets, (4) OHCA's role in promoting quality and equity, alternative payment models, and primary care and behavioral health investments, and (5) OHCA's role in reviewing transactions and market trends.

I. The Office of Health Care Affordability and Health Care Affordability Board

The Act establishes OHCA within the Department of Health Care Access and Information ("HCAI"), which was formerly the Office of Statewide Health Planning and Development ("OSHPD"). Among other things, OHCA is responsible for increasing health care cost transparency; supporting the Board through data collection, analysis, and recommendations; and overseeing California's progress toward meeting the health care cost targets set by the Board. OHCA has authority to adopt and promulgate necessary rules and regulations, which may be adopted as emergency regulations until January 1, 2027, provided that each rule and regulation is discussed in at least one Board meeting before adoption. Board meetings are scheduled to begin in the first half of 2023, but at the time of writing, the Board has not been appointed and the emergency regulation process has not yet begun.

The Board is responsible for establishing statewide health care cost targets as well as targets for particular sectors defined by the Board and defining exempted providers. It will also approve the methodology for setting targets and adjustment factors, the scope and range of penalties, benchmarks for primary care and behavioral health spending, statewide goals for alternative payment models ("APMs"), and standards to advance the stability of the health workforce.

The Board will be comprised of seven voting members (California's Health and Human Services Secretary, four appointees from the Governor's Office, and one appointee each from the Assembly and the Senate) and one nonvoting member (the CalPERS Chief Health Director or their deputy). Appointed members cannot receive financial compensation from or be employed by a health care entity that is subject to the cost targets, with certain exceptions.

Finally, the Board will establish a Health Care Affordability Advisory Committee to provide input and recommendations to the Board and OHCA. The Board will appoint the members of the advisory committee, aiming for broad representation, including representatives of consumer and patient groups, payers, fully integrated delivery systems, hospitals, organized labor, health care workers, medical groups, physicians, and purchasers. Advisory Committee members will likely be appointed by June 2023, with meetings beginning in the latter half of 2023.

II. Health Care Cost Targets

The establishment and enforcement of statewide and sector-specific health care cost targets is central to the Act. These targets will focus on total health care expenditures (aggregate and per capita), which is defined as all health care spending in California by public and private sources, including claims-based payments and encounters for covered health care benefits, non-claims based payments for covered health care benefits (*e.g.*, capitation, salary, global budget, other APMs, or supplemental Medi-Cal provider payments), Californian's cost sharing for covered health care benefits; administrative costs and profits, and pharmacy rebates and any inpatient or outpatient prescription drug costs not otherwise captured. This work will begin with emergency regulations for total health care expenditure data collection and the development of a statewide cost growth target methodology in 2023.

In early 2024, the Board will establish a statewide health care cost target for the 2025 calendar year. The first year will be a reporting year only, but for 2026 and subsequent years, the statewide health care cost target will be subject to enforcement. Sector-specific targets will be adopted within six years based on sectors defined before October 1, 2027.

The setting and monitoring of targets will be accompanied by data collection and reporting. Data submissions will begin by September 1, 2024, with payer and fully integrated delivery system data on 2022 and 2023 total health care expenditures, which will inform OHCA's baseline report released by June 1, 2025. Thereafter, OHCA will prepare and publish annual reports on health care spending trends and underlying factors with recommendations to control costs and improve quality performance and equity. These reports will draw from data collected directly from health care entities as well as public and private data sources, including data from other regulators on expenditures, premiums, cost sharing, benefits, medical loss ratios, and health equity and equality measures. Stakeholders and the public will have an opportunity to comment on the findings in OHCA's annual reports.

A. General Requirements for Targets and Methodology

The Board, after receiving input from OHCA and the advisory committees and public comments, is required to develop, apply, and enforce cost targets that promote a predictable and sustainable rate of change. Both the statewide and sector-specific health care cost targets will be set on a calendar-year basis and updated periodically with consideration for multiyear targets to promote consistency. The targets must be developed based on a methodology that is available and transparent to the public and be based on a target percentage, accounting for relevant adjustment factors (*see* Part II.B, below) and considering economic indicators (*e.g.*, measures reflecting the broader economy, labor markets, and consumer cost trends) or population-based measures (*e.g.*, demographic factors that may influence demand for services). The targets must also balance affordability with quality and equity, taking into consideration the impact on persons with disabilities and chronic illness. The Act also acknowledges critical workforce considerations that impact costs, requiring that the targets promote the stability of the healthcare workforce, including the development of the future workforce (*e.g.*, graduate medical education teaching, training, apprenticeships, and research) and that targets be adjusted for a provider or fully integrated delivery system upon a showing that nonsupervisory

employee organized labor costs are projected to grow faster than the rate of any applicable cost targets.

The methodology for setting health care cost targets will be developed by OHCA and approved by the Board in 2023. The Act requires that the methodology review historical trends and projections for economic indicators; population-based measures; Medi-Cal, Medicare, and commercial health care coverage costs, taking COVID-19 impacts on the 2020 and 2021 data into account. The methodology must also review potential factors to adjust future cost targets. Such factors may include the health care employment cost index, labor costs, the consumer price index for urban wage earners and clerical workers, impacts due to known emerging diseases, trends in the price of health care technologies, provider payer mix, state or local mandates such as required capital improvement projects, and any relevant state and federal policy changes impacting covered benefits, provider reimbursement, and costs. The methodology must allow the Board to adjust cost targets downward and upward when warranted based on cost and quality or to account for actual or projected nonsupervisory employee organized labor costs (*see* Part II.B, below).

The Act also includes some additional Medi-Cal-specific requirements. In particular, the methodology must consider provision of the nonfederal share associated with Medi-Cal payments and allow the Board to adjust any targets for Medi-Cal participating providers upon the request of California's Department of Health Care Services ("DHCS") and to the extent necessary for the Medi-Cal program to comply with federal requirements. The methodology may also consider (i) supplemental payments to qualifying providers who provide services to Medi-Cal and underinsured patients; (ii) reimbursements and fees assessed by DHCS as determined appropriate by the DHCS director; and (iii) health care-related taxes or fees that provide the nonfederal share or support the Medi-Cal program.

B. Adjustments

The Act contemplates (or, in the case of adjustments accounting for nonsupervisory organized labor costs, requires) certain adjustments to cost targets, as follows:

- *Cost and Quality Adjustments (Health & Safety Code § 127502(d)(6)).* OHCA's methodology for setting targets must allow the Board to adjust cost targets downward (for entities that deliver high-cost care that is not commensurate with quality) and upward (for entities that deliver low-cost, high-quality care) when warranted. Data sources on cost and quality may include cost and quality performance data reported by or sourced from recognized quality improvement and transparency initiatives, relevant supplemental data (*e.g.*, financial data submitted to California agencies and data on costs, payments and quality from California's all-payer claims database), and relevant federal, state, or local data.
- *Labor Adjustments (Health & Safety Code § 127502(d)(7))* With respect to adjustments based on nonsupervisory employee organized labor costs, in order for the adjustment to be effectuated, the provider, the fully integrated delivery system, or other associated part must submit a request with supporting documentation in an OHCA-prescribed format. OHCA may request or accept further information (*e.g.*, any single labor agreement that is final and reflects the actual or projected increase in nonsupervisory employee organized labor costs) to validate the basis for the requested adjustment. OHCA may audit the submitted data and supporting information as necessary.
- *Risk Adjustment Methodologies (Health & Safety Code § 127502(f)).* OHCA is also charged with establishing risk adjustment methodologies. These methodologies may rely on existing methodologies and must consider the impact of perverse incentives that may inflate the measurement of population risk (*e.g.*, upcoding). To the extent that upcoding or other factors skew risk factor reporting, OHCA may audit submitted data and make periodic adjustments.
- *Equity Adjustment Methodologies (Health & Safety Code § 127502(g)).* OHCA is also required to establish equity adjustment methodologies to take into account social determinants of health and other factors related to health equity, to the extent data is available and the methodology has been developed and validated.

C. Specific Targets

By June 1, 2028, the Board will establish sector-specific cost targets for fully integrated delivery systems

and other sectors (*e.g.*, geographic regions and included health care entities) defined by the Board. These targets must be informed by historical cost and other data as well as consideration of access, quality, equity, and health care workforce stability and quality jobs, and they may be adjusted to account for the baseline costs in comparison to other health care entities in the sector and geographic region. The Act includes additional requirements for targets for individual health care entities, payers, and fully integrated delivery systems, as follows:

- **Sector Target for Individual Health Care Entity.** The methodology for setting a sector target for an individual health care entity (*i.e.*, a payer, provider, or fully integrated delivery system) must consider an entity's status as a high-cost outlier, permit targets that encourage the entity to serve populations with greater health care risks through risk factor, equity, and geographic cost adjustments.
- **Payer Targets.** Payer is broadly defined as private and public health care payers, including publicly funded health care programs (*e.g.*, Medi-Cal and Medicare), Knox-Keene Plans, health insurers (including behavioral health-only policies), Medi-Cal managed care plans, third party administrators, and any other public or private entity other than an individual that pays for arranges for the purchase of health care services on behalf of employees, dependents, or retirees. In setting targets for payers, the Board will establish targets on payers' administrative costs and profits. OHCA will consult with California's DHCS, Department of Managed Care ("DMHC"), and Department of Insurance to ensure that targets for payers consider actuarial soundness and rate review requirements.
- **Fully Integrated Delivery System Targets.** Each fully integrated delivery system will be a sector subject to sector-specific targets. A fully integrated delivery system is a system that includes: (i) a physician organization, (ii) a health facility or health system, and (iii) a nonprofit health care service plan that provides services through an affiliate hospital system and an exclusive contract with a single physician organization in each geographic region. The Board will set targets applicable to each of the system's geographic service areas. Targets for fully integrated delivery systems will include all health care services, costs, and lines of business managed by the system (*i.e.*, individual, small, and large group plans, Medi-Cal, Medicare, Covered California, and self-insured public employee health plans). Until the Board approves sector targets for fully integrated delivery systems, the systems will be required to comply with the statewide cost target.

D. Exempted Providers

Certain physician practices and other qualifying providers are "exempted providers" that are not subject to statewide and sector-specific health care targets and direct data collection requirements. By statute, any physician practice is exempted if it does not qualify as a "physician organization" (*i.e.*, a risk-bearing organization or a similar organization; a restricted or limited health care service plan; a section 1206(*l*) medical foundation; an organization—including a medical group practice, professional medical corporation, or medical partnership—that is comprised of 25 or more physicians; an organization of less than 25 physicians that is a high-cost outlier). Other providers may be exempted based on standards established by the Board and OHCA regulations. Relevant factors for exemption may include annual gross and net revenues, patient volume, and high-cost outlier status in a given service or geographic region. The Board will consider any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the provider or vice versa. It appears that a provider that is part of a fully integrated delivery system could nonetheless qualify as an exempted provider because the Act specifies that such an exempted provider is not subject to data collection by OHCA.

E. Monitoring Workforce Stability

The OHCA will also monitor health care workforce stability and develop standards to assist entities in implementing cost-reducing strategies that advance the stability of the health care workforce (and do not exacerbate existing shortages). These standards will be developed on or before July 2024 in consultation with the Board and with input from organized labor, health care entities, and other entities and individuals with expertise in the health care workforce. These standards may be considered in setting cost targets or in the approval of performance improvement plans

(discussed in the following section).

III. Enforcement of Cost Targets

The Act provides the Director of HCAI (the "Director") with the power to enforce cost targets against health care entities, including the ability to assess administrative penalties following progressive enforcement measures. Health care entities may seek waivers of enforcement actions due to reasonable factors outside the entity's control and consistent with OHCA waiver requirements. In addition, the Director may impose administrative penalties directly for the repeated failure to file or implement an acceptable performance improvement plan, the willful failure to report complete and accurate data, the knowing failure to provide required information, or the knowing falsification of information as specified in Health & Safety Code section 127502.5(h). Because the setting of cost targets is a necessary predicate to most enforcement actions, the first enforcement actions will likely not begin for several years.

Enforcement actions will generally consist of the following progressive enforcement actions: (1) technical assistance; (2) the entity's public testimony on its failure to comply with the target; (3) performance improvement plans; and (4) escalating administrative penalties. However, OHCA may proceed directly to administrative penalties in some circumstances. In taking enforcement actions, the Director will consider each health care entity's contribution to cost growth in excess of the applicable target, factors contributing to that growth, and the extent to which the entity has control over spending growth.

Before taking any enforcement action, OHCA must first notify the health care entity that it has exceeded the health care cost target. The health care entity will then have at least 45 days to respond and provide additional data, including information in support of a waiver. If OHCA determines that the additional data and information provided by the health care entity meets the burden to explain all or a portion of the excess cost growth, OHCA will then modify its findings as appropriate. In the case of a payer regulated by DMHC, DHCS, or the Department of Insurance, OHCA will also consult with the applicable agency to ensure any measures are consistent with laws applicable to the payer.

A. Performance Improvement Plans

OHCA may require a health care entity to submit and implement a performance improvement plan that identifies the causes for spending growth and includes, among other things, specific strategies, adjustments, and action steps the entity proposes to implement to improve spending performance during a specified time period. Performance improvement plans may be approved for up to three years, and a plan will not be approved if it is likely to erode access, quality, equity, or workforce stability. As part of the approval process, OHCA will request further information, as needed. OHCA will publicly post a detailed summary of the health care entity's compliance with the performance improvement plan while it is in effect and will transmit the approved plan to the appropriate state regulators for the entity.

OHCA will monitor the health care entity for compliance with the approved performance improvement plan. The Director will not assess administrative penalties from an entity that fully complies with an approved performance improvement plan by OHCA-established deadline but nonetheless does not meet the cost target, but the Director may require a modification to the performance improvement plan until the cost target is met.

B. Administrative Penalties

Administrative penalties may be imposed as part of progressive enforcement measures where an entity fails to comply with an approved performance plan and fails to meet the cost target, and may also be assessed directly where an entity (1) willfully fails to report complete and accurate data, (2) repeatedly neglects to file a performance improvement plan with OHCA, (3) repeatedly fails to file an acceptable performance improvement plan with OHCA, (4) repeatedly fails to implement the performance improvement plan, (5) knowingly fails to provide required information to OHCA, and (6) knowingly falsifies information. In these cases, the Director may also notify the public of the violation at a public meeting and may "declare the entity as imperiling the state's ability to monitor and control health care growth."

The amount of an administrative penalty must generally be commensurate with the failure of the health care entity to meet the target. But, if the entity is repeatedly noncompliant with the performance improvement plan, the Director may

assess escalating administrative penalties. In assessing administrative penalties, the Board will consider the following factors:

- The nature, number, and gravity of the offenses.
- The fiscal condition of the health care entity, including revenues, reserves, profits, and assets of the entity, as well as any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the entity or are subject to the control, governance, or financial control of the entity.
- The market impact of the health care entity.

Administrative penalties are not considered expenditures for the purposes of meeting cost targets, and do not relieve the penalized entity of the obligation to meet previously established or subsequent cost targets. Penalties recovered will be deposited into the Health Care Affordability Fund.

C. Waiver of Enforcement Action

OHCA can require health care entities to file for a waiver of enforcement actions because of reasonable factors outside the entity's control, such as changes in state or federal law or anticipated costs for investments and initiatives to minimize future costly care. The health care entity must submit documentation or supporting evidence of the reasonable factors, anticipated costs, or extraordinary circumstances. OHCA may request further information, as needed, to approve or deny an application for a waiver.

In addition, if data indicate adverse impacts on cost, access, quality, equity, or workforce stability from consolidation, market power, or other market failures, the Director may, at any point, require that a cost and market impact review on a health care entity.

D. Review and Appeal Rights

Although the Act does not explicitly set out the requirements concerning administrative and judicial review of administrative penalties, it does confirm the use of an administrative hearing process and the availability of independent judicial review of the order. After issuance of the final order imposing the administrative penalty, an entity adversely affected by the order may seek independent judicial review by filing a petition for a writ of mandate in accordance with section 1094.5 of the Code of Civil Procedure. Section 1094.5 authorizes judicial review of the following questions: (1) did the agency proceed without or in excess of jurisdiction, (2) was there a fair trial, and (3) was there any prejudicial abuse of discretion because the agency did not proceed in the manner required by law, the order was not supported by the findings, or the findings were not supported by the evidence. In general, Government Code section 11523 requires that such a petition for writ of mandate be filed within 30 days after the last day on which reconsideration could be ordered, but this time is extended to no later than 30 days after delivery of the administrative record if the petitioner requests that the agency prepare all or any part of the record within 10 days after the last day on which reconsideration could be ordered. If a petition for writ of mandate is not timely filed after issuance of a final order, OHCA may apply to the clerk of the appropriate court for a judgment in the amount of the administrative penalty by filing a certified copy of the final order of the administrative hearing officer. The court clerk will then enter the judgment immediately, and the judgment will have the same force and effect as a judgment in a civil action.

E. Confidentiality of Information

The Act requires that OHCA keep all nonpublic information and documents it obtains as confidential. OHCA will not disclose the confidential information or documents to any person without the consent of the source of the information or documents, except in an administrative penalty action, to the Attorney General, or at a public meeting. Before disclosure in a public meeting, OHCA will notify the relevant party and give the source of nonpublic information an opportunity to state why release of the information is damaging to it and why the public interest is served in withholding the information. All nonpublic information and documents obtained under this subdivision is not disclosable to the California Public Records Act.

IV. Promotion of Quality, Equity, Alternative Payment Models, Primary Care, and Behavioral Health

Although the Act primarily focuses on affordability, it includes key provisions focused on quality, equity, alternative payment models, primary care, and behavioral health. OHCA's

annual reports, the first of which is scheduled for release on or before June 1, 2027, will report on health care entities' performance on quality and equity measures, the adoption of alternative payment models, and primary care and behavioral health spending and growth.

A. Quality and Equity

The OHCA will also adopt and annually update a set of standard measures for assessing health care quality and equity across health care service plans, health insurers, hospitals, and physician organizations ("Quality & Equity Measures"). In drafting these standards, OHCA will consider recognized clinical quality, patient experience, patient safety, and utilization measures and input from other agencies (*e.g.*, DMHC), quality improvement organizations, and stakeholders. Furthermore, the Quality & Equity Measures must reflect California's diversity and consider available means for measuring disparities in terms of "race, ethnicity, sex, age, language, sexual orientation, gender identity and disability status." Where possible, OHCA will reduce administrative burdens by simplifying reporting, aligning performance measurement with other programs, and using existing voluntary and required reporting. OHCA will also encourage all payers and programs to use the same reporting mechanisms. Future rulemaking will likely provide further clarity on the Quality & Equity Measures. As more fully described in Part II, above, health care cost targets will reflect and may be adjusted based on quality and equity considerations, and the quality and equity components of these targets and adjustments will presumably be informed by Quality & Equity Measures.

B. Alternative Payment Models

In pursuit of the goal of "rewarding equitable high-quality and cost-efficient care," OHCA is charged with convening an APM working group, developing standards for APMs, and measuring progress against those standards. The benchmarks must include "increasing the percentage of total health care expenditures delivered through [APMs] or the percentage of membership covered by an [APM]."

An APM is defined under the Act as "state or nationally recognized payment approach that financially incentivizes high-quality and cost-efficient care." The standards set for APMs must meet various statutory requirements, including a "focus on encouraging and facilitating multipayer participation and alignment, improving affordability, efficiency, equity and quality by considering the current best evidence for strategies such as investments in primary care and behavioral health, shared risk arrangements, or quality-based or population-based payments." The standards must be set by July 1, 2024, and be reviewed and updated at least once every five years. The statute does not set out consequences for failure to meet the benchmarks, but payers and fully integrated health systems will be required to submit data and other information to OHCA to measure the adoption of APMs.

C. Primary Care and Behavioral Health Spending Benchmarks and Promotion

Recognizing that primary and behavioral health care is foundational to an effective health care system, OHCA will measure and promote investment in primary and behavioral health care in California through spending benchmarks. These benchmarks are intended to "build and sustain infrastructure and capacity," with a particular focus on "methods of reimbursement that shift greater health care resources and investments away from specialty care and toward supporting and facilitating innovation and care improvement in primary care and behavioral health." In setting these spending benchmarks, OHCA will consider current and historical underfunding of primary care services as well as differences among payers and fully integrated delivery systems (*e.g.*, plan or network design or line of business, diversity in primary care settings and facilities, the use of claims- and non-claims-based payments, and population risk mix). The spending benchmarks are not intended to increase costs, although the Act acknowledges that shifting resources within the systems may be an extended process that will not result in immediate cost savings.

OHCA will also be responsible for promoting improved outcomes for primary care and behavioral health, including health care entities' investment in or adoption of models that do any or all of the following:

- Promote the importance of primary care and adopt practices that give consumers a regular source of primary care.
- Increase access to advanced primary care models and adoption of measures that demonstrate

their success in improving quality and outcomes.

- Integrate primary care and behavioral health services, including screenings for behavioral health conditions in primary care settings or delivery of behavioral health support for common behavioral health conditions, such as anxiety, depression, or substance use disorders.
- Leverage alternative payment models that provide resources at the practice level to enable improved access and team-based approaches for care coordination, patient engagement, quality, and population health. Team-based approaches support the sharing of accountability for delivery of care between physicians and nurse practitioners, physician assistants, medical assistants, nurses and nurse case managers, social workers, pharmacists, and traditional and nontraditional primary and behavioral health care providers, such as peer support specialists, community health works, and others.
- Deliver higher value primary care and behavioral health services with an aim toward reducing disparities.
- Leverage telehealth and other digital health solutions to expand access to primary care and behavioral health services, care coordination, and care management.
- Implement innovative approaches that integrate primary care and behavioral health with broader social and public health services.

V. Transaction Review and Market Trends

OHCA will review a wide range of potential healthcare transactions and their likely effect on the healthcare marketplace beginning in 2024. Specifically, any payer, provider, or fully integrated delivery system must provide OHCA with 90 days advance written notice of any "material change" that will occur on or after April 1, 2024, with some exceptions (discussed further below). A material change involves either (1) the disposition (including, sale, transfer, lease, exchange, option, encumbrance, or conveyance) of a material amount of the entity's assets to one or more entities or (2) a transfer of control, responsibility, or governance of a material amount of the assets or operations of the health care entity to one or more entities. OHCA then has 60 days to decide if the proposed material change is likely to have a significant impact on competition, on California's ability to meet cost targets, or on costs for purchasers and consumers, in which case OHCA notifies the health care facility that it will conduct a "cost and market impact review" of the health care entity's market position, including size and market share by service or geographic region, prices compared to competitors, quality, equity, cost, access, or "any other factors" OHCA determine to be in the public interest.

If OHCA determines such a review is not needed, then it can grant a waiver. The bill prohibits a material change from moving forward unless a final report has been issued or OHCA has issued a waiver. In addition to preparing a report, OHCA may refer its findings, including documents gathered and data analysis performed, to the Attorney General for further review of any unfair competition, anticompetitive behavior, or anticompetitive effects.

The health care entity must promptly reimburse OHCA for the actual, reasonable, and direct costs it incurs reviewing, evaluating, and making its determination, upon request by the office. In addition to any other available legal remedies, OHCA is entitled to specific performance, injunctive relief, and other equitable remedies to enforce these laws, and is entitled to attorneys' fees and costs incurred in remedying any violation.

Notably, the requirement to provide notice of a material change does not apply to certain organizations, some of which are already subject to comparable regulatory oversight: (1) health care service plans subject to review by DMHC; (2) health insurers subject to review by the Insurance Commissioner; (3) health care entities under the control of, and operated by, a political subdivision; and (4) agreements or transactions involving nonprofits for which the Attorney General's approval is required. The requirement generally applies to the same "health care entities" that are subject to the cost targets also established under the statute, and the same set of "exempted providers" are exempt, though a transaction is subject to review if an exempted provider is being acquired by, or affiliating with, an entity that is not an exempted provider. Specifically, an "exempted provider" includes certain physician organizations with fewer than 25 physicians, and any other provider that satisfies standards to be set by the Board for exemption. The definition of an

"exempted provider" is discussed in more detail above in Part II.

OHCA is also directed to adopt regulations setting appropriate criteria for the types of agreements or transactions for which a notice must be submitted (*e.g.*, based on patient revenue, or market share in a given service or region), as well as regulations outlining factors to be considered in OHCA's review, and relevant timelines, and to establish appropriate fees.

ENDNOTES

1 https://hcai.ca.gov/ohca/.

2 SB 184, Chapter 42, Statutes of 2022 (codified at Cal. Health & Safety Code, Division 107, Part 2, Chapter 2.6).

3 Cal. Health & Safety Code § 127500.5(a).

CALIFORNIA CEMENTING ITS LEADERSHIP AS A REPRODUCTIVE HEALTH RIGHTS STATE

by **Fabiola Carrión**
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Fabiola Carrión is the Director, Reproductive and Sexual Health at the National Health Law Program's Los Angeles office, where she works on reproductive and sexual health access and services in California and across the country. Her portfolio focuses on abortion coverage at the state level, primarily in Medicaid and the marketplaces. Fabiola also coordinates NHeLP's groundbreaking work on telehealth by ensuring that Medicaid enrollees are centered in emerging telehealth policies.

I. California's current abortion protections

California has long enjoyed protections to abortion access. Currently protected under the right to privacy in the State Constitution, pregnant people in the State have a fundamental right to choose to have an abortion.[1] Moreover, a pregnancy-capable person may have an abortion under any circumstances and without medical justification.

Trained doctors, licensed nurses/midwives, nurse practitioners, and physician assistants can perform abortions in California. In addition, a minor may have an abortion without consent or involvement of their parent/guardian, spouse, or the biological parent of the fetus.[2] For the most part, California lacks restrictions found in other states.[3]

Also since the 1970s, California has required abortion coverage in state-based health plans. According to the Knox-Keene Act, state plans must cover "all basic health services," which includes physician services, inpatient hospital services and ambulatory care services, outpatient hospital services, and family planning services.[4] Abortions encompass these services. California is one of seven states that require abortion coverage in all state plans—including Medi-Cal, Covered California, and private or employer-based insurance.[5]

II. The creation of the California Future of Abortion Council

Although California has one of the strongest state legal abortion protections in the country, abortion access is not available for everyone who seeks care in the State as explained by Catherine Cohen in *The Impact of Dobbs on Abortion Care in California* in the prior CSHA publication. Following the implementation of Texas Senate Bill 8 in September 2021, a law that bans abortion at six weeks of gestational age and creates a bounty hunter mechanism for those who assist in the procurement of an abortion,[6] around 200 people formed the California Future of Abortion ("FAB Council"). FAB Council was designed to formulate policy recommendations that would make the State a haven for abortion access. The FAB Council is comprised of reproductive freedom and sexual and reproductive health care allies, partners, and leaders who work in collaboration with policy makers, providers, patients, and key constituents to address challenges in the State and recommend solutions that will continue to provide access and stability for both Californians and those who may seek services here from out of state.[7]

On December 8, 2021 the FAB Council released a blueprint outlining forty-five recommendations, known as "the report". The report detailed what policymakers can implement to better prepare California against the national threat to abortion rights. More than 40 national and state-based organizations signed onto the report and its recommendations.

III. Legislative Efforts in 2021

Soon after the report's publication, advocates quickly pivoted towards helping to draft legislation and creating a list of requests for the

Governor's proposed budget. Thanks to the coordinated efforts of these advocates, the legislature, and the executive branch, more than fifteen bills were introduced in the 2022 legislative session that came from the report created by FAB Council. These bills are divided into four different categories: (A) Addressing Cost Barriers; (B) Workforce Development; (C) Legal Protections; and (D) Health Equity.

A. Addressing Cost Barriers

The first signed bill of the session, the Abortion Accessibility Act (**Senate Bill 245**), requires state-licensed commercial health plans and insurers to cover abortion care without imposing co-payments, deductibles, or any other type of cost-sharing.[8] These protections apply to commercial health plan enrollees as well as covered spouses and dependents, and to Medi-Cal beneficiaries. Thanks to this law, abortion patients will no longer have to meet a high deductible in order to receive insurance coverage, meaning that it will save hundreds or thousands of dollars for Californians seeking this type of care.

Assembly Bill 2134, the California Abortion and Reproductive Equity Act, provides grants to providers who offer free reproductive and sexual health care to patients with low incomes and those who lack health care coverage for reproductive health services, including those who come from out of state.[9] Safety net providers, like those who accept Medi-Cal, will be eligible to apply to a newly created California Reproductive Health Equity Grant Program. The law means that people who seek abortion care and cannot afford the service may qualify for an abortion free of charge in the state; it will also prevent providers from having to absorb the costs of these time-sensitive services. To illustrate the losses incurred by abortion clinics, Planned Parenthood health centers in California provided about nine million dollars of uncompensated care to patients in 2019.[10] The bill not only guarantees abortion access but stabilizes the abortion provider network in the State.

When Californians have to travel hundreds of miles to obtain abortion care, they not only have to pay the costs for the procedure itself but everything that is entailed with making a trip to see a provider. **Senate Bill 1142**, the Access and Support for Abortion Patients Act, creates a fund for organizations that provide financial and logistical support—like travel, childcare, food, and lodging—to patients who face barriers to accessing abortion care.[11] A patient may have to worry about spending thousands of dollars in addition to the abortion. This bill also requires the California Health and Human Services Agency to develop and maintain a website with comprehensive and accurate information regarding accessing abortion services in California and also to provide patients one point of entry to connect with the nearest and most accessible abortion provider. The bill promises to be an accessible and truthful information hub for those who seek abortions in California and want to learn their rights.

The Affordable Care Act's ("ACA") Section 1303 sets forth special rules regulating abortion coverage in the marketplaces, like Covered California.[12] In accordance with this federal law, marketplace insurers must segregate premiums in two separate accounts: one account for payment for all services for all services and exempted abortions (those that involve a life endangerment situation or the pregnancy was the result of rape or incest), and a second account for all other abortion services. Payments for non-abortion services (and exempted abortions) are used exclusively to pay for those services, and all payments for abortion services are placed in a different account that is used exclusively to pay for them. **Assembly Bill 2205**, the Disclosure Requirement for Abortion Premiums Act, requires each Covered California plan to report annually the total amount of funds in the segregated account maintained pursuant to the ACA.[13] More specifically, it requires the annual report to include the ending balance of the account and the total dollar amount of claims paid during a reporting year. Thanks to this bill, Californians will be able to learn how much each state insurance carrier has collected in abortion funds since 2014. Back in 2019, the California's Insurance Commissioner estimated that $53 million of consumers' premium dollars sat on these abortion premium accounts.[14] These are monies that should be used to help pay for abortion services.

B. Workforce Development

Assembly Bill 1918[15] creates the California Reproductive Health Scholarship Corps, which will be responsible for recruiting, training, and retaining a diverse workforce of health care professionals who will

provide reproductive health services, including abortions, in underserved areas of California. The law promises to improve California's health care education pipeline, build institutional training capacity, and prepare and retain a diverse workforce to provide essential reproductive health care. Current abortion providers will receive educational scholarships, living wage stipends, and loan repayment options. Ultimately, the bill will ensure that people can obtain reproductive health care, including abortion care, from trusted providers in their communities.

Assembly Bill 2529 expands the Song-Brown Workforce Training Act program, which aims to increase the number of students and residents receiving quality primary care education and training in areas of unmet need throughout California, to include Certified Nurse-Midwifery and Licensed Midwifery training programs.[16] Traditionally, eligible applicants for the Song-Brown program did not include midwives. The law is important because the state is in the midst of a maternity workforce crisis, with nine counties lacking OB/GYNs and many more counties being recognized as "limited access areas." Major urban and rural counties in California are projected to have critical maternity care provider shortages by 2025 and this bill ensures that more qualified providers will be available to offer the full range of reproductive health care across the State.[17]

Senate Bill 1375 confirms that nurse-practitioners who meet specified criteria and training requirements can provide first trimester abortions without physician supervision.[18] Although a prior law, AB 890, removed physician supervision requirements for early abortion, this bill clarifies that nurse practitioners who have been practicing for three or more years satisfy the transition-to-practice ("TTP") requirement and allows nurse practitioners to utilize prior practice experience to satisfy the TTP. This bill will also address the shortage of health care professionals able to provide early abortion care.

C. Legal Protections

In the past two decades, at least 1,300 pregnant people have been criminally prosecuted for having miscarriages or stillbirths, or self-managing abortions in the United States.[19] California has not been exempt from these prosecutions. Despite clear law establishing that ending or losing a pregnancy is not a crime, prosecutors have charged people in California with homicide offenses for pregnancy losses.[20] **Assembly Bill 2223** ensures that no one in California will be investigated, prosecuted, or incarcerated for ending a pregnancy or experiencing pregnancy loss.[21] The bill clarifies that the Reproductive Privacy Act prohibits pregnancy criminalization, and creates a private right of action for people whose rights have been violated to seek accountability using civil courts. It will also remove outdated provisions requiring coroners to investigate certain pregnancy losses, and ensure that information collected about pregnancy loss is not used to target people through criminal or civil legal systems.

Assembly Bill 1666 protects patients and providers in California from civil liability judgments for providing reproductive health care to patients when the claims are based on laws in other states that are hostile to abortion rights and are contrary to California public policy.[22] The bill protects anyone who could be sued as a defendant in actions involving reproductive rights by prohibiting seizure of their financial assets in California. In other words, if a judgment or penalty goes through a California court, a patient or provider's assets in California would be shielded from seizure.[23]

Assembly Bill 2091 enhances privacy protections for medical records related to abortion care against disclosures to law enforcement and out-of-state third parties seeking to enforce hostile abortion bans in other states. Specifically, the law prohibits health plans from disclosing medical information of a person seeking an abortion in response to a foreign subpoena based on the violation of another state's law. It also authorizes the California Insurance Commissioner to assess a civil penalty against an insurer that has disclosed an insured's confidential medical information.[24]

Assembly Bill 2626 protects abortion providers by preventing the Medical Board of California from revoking or suspending a medical license for a licensee providing abortion care in California and other states.[25]

Assembly Bill 657 expedites licensure for providers committed to providing abortion care in California.[26] To meet the needs of Californians and those traveling to California from other states, the bill will provide licensing to various Boards—including the Medical Board, the Osteopathic Medical Board, the Board of Registered Nursing, and

the Physician Assistant Board—to prioritize review for licensing for an applicant that demonstrates they will provide abortion, within their scope of practice in California.

Assembly Bill 1242 will protect California providers and patients from specified law enforcement actions—such as issuing subpoenas, cooperating or providing information to another state or federal law enforcement agency— that stem from any investigations based on providing or accessing abortion that is legally allowed in California.[27] The law also prohibits law enforcement from carrying out arrests that are based on hostile laws from other states and prohibits an arrest in California of someone who provides, aids in the performance of, or receives an abortion in California.

D. Health Equity

Los Angeles County is home to 28 percent of the State's population and accounts for over a third of all abortions that take place in California.[28] This prevalence, coupled with the County's role as a major metropolitan transportation hub with multiple airports, makes it highly likely that nonresidents will come to Los Angeles County for the abortion care they will not be able to access in their home state or county. **Senate Bill 1245** establishes a reproductive health pilot project in Los Angeles to support innovative approaches and patient-centered collaborations to safeguard patient access to abortions, regardless of residency.[29] More specifically, the law will improve the navigation and coordination between health networks and community-based organizations within Los Angeles County and California.

Black, Indigenous, Latine[30], and other communities of color continue to face increasingly higher rates of sexual and reproductive health inequities across California including: inequitable access to abortion information, care, and related services, inequities in sexually transmitted infection rates, and inequities in accessing contraceptive care.[31] **Assembly Bill 2586** establishes a working group with specified membership to examine the root causes of the reproductive health and sexual health inequities in California, and establishes the California Reproductive Justice and Freedom Fund to support community-based organizations to provide medically accurate, culturally congruent, comprehensive reproductive and sexual health education, inclusive of abortion, to disproportionately impacted communities.[32]

Thanks to the historic bill package sponsored by the FAB Council, California not only protects the right to abortion, but guarantees that access to abortion care becomes a reality for Californians and those who come from other states. Altogether, these laws ensure that abortion is affordable for everyone in the State and that patients know where to go to obtain verifiable and medically accurate information. The bill package also protects the freedoms, including the right to privacy, of both patients and providers as well as ensures that there is the adequate workforce – in the form of provider training and recruitment - throughout the state to be able to serve every abortion patient in the State. The package recognizes that it takes everyone: including providers, law enforcement, health care plans, and community-based organizations to make reproductive freedom a reality.

IV. Budget Commitments

For the first time, more than $200 million has been allocated through a state budget to expand abortion access and other forms of reproductive and sexual health care. In addition to the investment needed for the bills described above, the California budget includes funding for: equity and infrastructure payments for clinic abortion providers, abortion premium subsidy payments, the Title X family planning program, as well as other family planning, access, care and treatment and HPV vaccine coverage.[33]

V. Other Policy Wins

Along with legislators and the Governor, other policymakers have taken steps to strengthen and enforce abortion rights in the State. Early in 2022, California Attorney General Rob Bonta issued a statewide alert to ensure that people who are pregnant and experience pregnancy loss are not burdened by improper and unjust criminal charges. The legal alert was issued to all California district attorneys, police chiefs, and sheriffs making clear that Section 187 of the California Penal Code was intended to hold accountable those who inflict harm on individuals who are pregnant resulting in fetal death, not to punish people who suffer the

loss of their pregnancy.[34] On June 13th, 2022, Attorney General Bonta issued Bulletin No. 2022-DLE-06, indicating that law enforcement agencies must enforce the California Freedom of Access to Clinic and Church Entrances Act and additional laws relating to reproductive health care clinic security. The Bulletin also outlined law enforcement reporting requirements concerning anti-reproductive rights crimes as defined by the Reproductive Rights Law Enforcement Act.[35] Finally, on October 20, 2022, General Bonta issued guidance to law enforcement on AB 1242, making it illegal for law enforcement to assist in out-of-state investigation and enforcement efforts related to providing, facilitating, or obtaining abortion that is lawful in California.[36]

The California Department of Health Care Services ("DHCS") has also made policy changes to expand abortion access for Medi-Cal beneficiaries, In July 2022, it published its, "PHE Telehealth Policy Clarification for Medication Abortion."[37] The policy, which will hopefully be made permanent, will ensure that Medi-Cal beneficiaries have access to teleabortions and that providers do not need to conduct ultrasounds or do follow-ups when they are not necessary in order to receive a bundled payment. It offers some flexibility to the abortion provider to offer care in a way that best meets the patient's needs. In addition, DHCS announced it will provide Federally Qualified Health Centers ("FQHC"s), Rural Health Clinics, Indian Health Services Memorandum of Agreement, and Tribal FQHC providers with a new option to be reimbursed at a fee-for-service rate for abortion services.[38] This measure means that more health centers, particularly those who serve marginalized populations, will also be able to provide abortion care.

Thanks to the lessons learned from California and the inspiration drawn from the creation of the FAB Council, other states and cities have created their own initiatives to advance abortion access. For example, Oregon has launched its Reproductive Health and Access to Care workgroup. Modelled after the FAB Council, advocates and policymakers are working to strengthen the reproductive health care workforce, improve protections for abortion patients and providers, and ensure that the abortion provider network has the capacity to serve the needs of Oregonians and those who come from other states seeking abortions. The final output will be a report with a series of recommendations for improving sexual and reproductive health care access in Oregon.

VI. Additional Measures in Development at the Time of Writing

Last November, Californians overwhelmingly voted in support on a ballot measure that enshrines the right to abortion and the right to accept or refuse contraception directly in the State Constitution.[39] Proposition 1, the Protect Abortion Rights ballot initiative, went into effect on December 21, 2022. It prevents a California version of the U.S. Supreme Court case *Dobbs v. Jackson Women's Health*, where a court interpreted away privacy-based abortion rights. Proposition 1 also subjects laws regulating abortion to the most stringent level of constitutional review.[40]

VII. Work that Remains to be Done

While the FAB Council secured a national and state record of 15 laws that will improve abortion access for anyone who steps foot in California, it must still push for the additional recommendations included in the report. For example, California must still address the gaps in abortion access in areas of the state that are served primarily by religiously affiliated hospitals. The State also can take additional steps to improve sex education like require school districts to participate in California Healthy Kids Survey and include a module on sexual and reproductive health care. The Department of Health Care Services should also improve access to and capacity of Medi-Cal Transportation Services, ensure that plans have fair and reasonable rates, and modernize the Presumptive Eligibility for Pregnant Women program.

In addition, the State should explore opportunities to improve retail pharmacy prescription and dispensing of medication abortion since the U.S. Federal Drug and Administration Agency recently loosened restrictions that only allowed direct provider provision. Lastly, as we enter a post-*Dobbs* world, the State has a chance to examine through research how these new laws and policies have been implemented in California in order to continue improving abortion access in the State.

ENDNOTES

1 Cal. Const. art. 1

2 *See Am. Acad. of Pediatrics v. Lungren*, 16 Cal. 4th 307 (1997) (holding that the right to privacy found in the California Constitution invalidates a statute requiring that pregnant minors obtain judicial or parental consent prior to abortion).

3 *See* Guttmacher Institute, State Facts About Abortion: California (June 2022), https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-california.

4 Cal. Health & Safety Code § 1340 et seq.

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THE IMPACT OF THE AUGUST 26, 2022, FEDERAL SURPRISE BILLING REGULATIONS ON HEALTH CARE PROVIDER OUT-OF-NETWORK REIMBURSEMENT IN CALIFORNIA

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On August 26, 2022, the federal Department of Health and Human Services promulgated its final rules (the "New Regulations") governing the reimbursement of certain out-of-network providers that provide specified services to patients covered by health maintenance organizations, health insurers, and employer-funded ERISA plans (collectively "Commercial Payors").[1] The New Regulations were promulgated under the federal No Surprises Act ("NSA")[2], which went into effect on January 1, 2022.[3] The New Regulations supplant previously issued interim final regulations that were successfully challenged in court as being inconsistent with the statutory language by making Health Plan's average payments for a good or service the presumptively correct payment amount under the Act. The New Regulations apply a more equitable reimbursement standard and are more consistent with the NSA's requirements than the interim final regulations that they replace because they allow the consideration of a wider variety of factors in determining the correct payment amount.

The New Regulations will have a limited impact on out-of-network provider reimbursement in California because the NSA only applies to certain Commercial Payors and the vast majority of claims against Commercial Payors will remain governed by California law. This article explores the impact of the New Regulations on provider reimbursement in California and compares the reimbursement methodology contained therein with the California reimbursement methodologies that will remain in effect.

1) Overview of the No Surprises Act

The NSA requires Commercial Payors to cover out-of-network emergency services and prohibits providers from billing the emergency patient more than the amount the patient would have owed if the services had been provided in-network (such as deductibles and co-payments), a practice commonly referred to as "balance billing."[4] The NSA also provides that an out-of- network provider treating a patient at an in-network facility cannot balance bill a patient unless the out-of-network provider obtains the patient's written informed agreement to pay a higher amount at least 72 hours before treatment is rendered.[5] The NSA requires Commercial Payors to timely pay the out-of-network providers appropriate amounts for their services and contains an independent dispute resolution ("IDR") process for determining the appropriate payment if the Health Plan and the provider cannot agree.[6]

The No Surprises Act's provisions regarding payment for out-of-network providers do not apply in states that: (1) have an applicable All-Payer Model Agreement that the state entered under section 115A of the Social Security Act; or (2) have "a specified state law" that protects patients from balance billing and provides a method for determining the total amount payable for out-of-network services.[7]

California does not have an applicable All-Payer Model Agreement, but does have several laws that qualify as specified state laws so that services covered by those laws continue to be governed by California law and not by the NSA.

2) The New Regulation's Methodology for Determining Payment for Covered Out-Of-Network Services

A) The NSA's Procedure for Determining the Out-of-Network Payment

Unlike California law, the NSA and the regulations promulgated thereunder set a single procedure for calculating a provider's reimbursement for out-of-network services irrespective of whether the payment is for an emergency service or for an out-of-network provider who is performing services at an in-network facility. The methodology for determining the appropriate payment is as follows:

a) The Health Plan is required to make an initial payment (or notice of denial of payment if the service is not covered) to the provider within 30 days of receiving the provider's bill. Neither the Act nor the regulations set forth a methodology for determining the amount of the initial payment.[8] The comments to the regulations state only that the "initial payment should be an amount that the plan or issuer reasonably intends to be payment in full based on the relevant facts and circumstances and as required under the terms of the plan or coverage."[9]

b) Along with the initial payment, the Health Plan is required to disclose the qualifying payment amount ("QPA") for each service.[10] The QPA is the median payment that the Health Plan (or Health Plan Administrator) pays to similar contracted providers or facilities in the same geographic area.[11] The QPA is used to determine the co-payment amount that the Health Plan member will be required to pay and is also a factor to be considered in the resolution of any payment disputes between the provider and the Health Plan.

c) If the provider is not satisfied with the initial payment, it can initiate an open-negotiation period by sending a notice to the Health Plan within 30 business days of receiving the initial payment.[12] The open-negotiation period begins on the date that the notice is sent and lasts for 30 business days. If the parties do not reach agreement during the open-negotiation period, either party can initiate the independent dispute resolution process by sending a notice to the other party and the Secretary (through the federal IDR portal) during the four-business-day period commencing on the 31st business day after the commencement of the open-negotiation period.[13] The NSA places significant limits on the bundling of claims into a single IDR proceeding, which will likely make the IDR process more cumbersome than it otherwise would be.

d) Within 10 business days after the selection of the IDR entity, each party must submit an offer of an out-of-network rate expressed as both a dollar amount and the corresponding percentage of the qualifying payment amount represented by that dollar amount along with other information required by the regulations and/or by the IDR entity. The IDR entity is required to choose one of the two offers as the required payment amount and issue its determination within 30 business days after the date on which the IDR entity was selected.[14]

B) Regulatory History Leading to the Adoption Of The New Regulations

The previously issued interim final regulation provided that "the certified IDR entity must select the offer **closest to the qualifying payment amount** unless the certified IDR entity determines that **credible information** submitted by either party under paragraph (c)(4)(i) **clearly demonstrates** that the qualifying payment amount is materially different from the appropriate out-of-network rate, or if the offers are equally distant from the qualifying payment amount, but in opposing directions. In these cases, the certified IDR entity must select the offer as the out-of-network rate that the certified IDR entity determines best represents the value of the qualified IDR item or services, which could be either offer."

This language in the interim final regulations was challenged in several court cases as being inconsistent

with the statutory language which contained no language stating that the QPA was the presumptively correct payment. In *Texas Medical Association v. United States Department of Health and Human Services*,[15] the court granted summary judgment in favor of providers challenging the regulations and vacated the portion of the regulations making the QPA the presumptively correct payment amount. In reaching its decision, the Court noted:

It is a "core administrative-law principle that an agency may not rewrite clear statutory terms to suit its own sense of how the statute should operate." *Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 328 (2014). But here, the Departments impermissibly altered the Act's requirements.

Rather than instructing arbitrators to consider all the factors pursuant to the Act, the Rule requires arbitrators to "select the offer closest to the [QPA]" unless "credible" information, including information supporting the "additional factors," "clearly demonstrates that the [QPA] is materially different from the appropriate out-of-network rate" (or if the offers are equally distant from the QPA in opposing directions). 45 C.F.R. § 149.510(c)(4)(ii)(A). The Departments in fact characterize the non-QPA factors as "permissible additional factors" that may be considered only "when appropriate." 86 Fed. Reg. at 56,080. The Rule thus places its thumb on the scale for the QPA, requiring arbitrators to presume the correctness of the QPA and then imposing a heightened burden on the remaining statutory factors to overcome that presumption.

The Department appealed the court's decision and then asked that the appeal be stayed while the Department completed its pending rulemaking proceedings.[16]

On August 26, 2022, the Department published its New Regulations in the *Federal Register*. The New Regulations no longer makes the QPA the presumptively correct payment and instead require the IDR entity to consider all the information that the statute allows the parties to submit and to give weight to all credible non-duplicative information.[17] The information that the IDR entity is required to consider in addition to the QPA include: (1) the level of the provider's training, experience, and quality; (2) the provider's market share; (3) the patient's acuity and the complexity of the services provided; (4) the facility's teaching status, case mix, and scope of services; (5) the parties' good faith efforts (or lack thereof) to enter into network agreements; (6) additional information requested by the IDR entity or offered by a party, provided that such information is not statutorily precluded from being considered.

The statute and regulations prohibit the IDR entity from considering: (1) usual and customary charges; (2) the provider's billed charges; and (3) payment rates used by governmental payors, such as Medicare and Medicaid. The IDR entity's decision is binding on the parties and is only subject to court review to the same extent as any other arbitration decision is subject to court review under the Federal Arbitration Act, so court review is extremely limited.

3) California's Specified State Laws That Supersede the No Surprises Act

California has laws governing health coverage provided by Commercial Payors licensed by the California Department of Managed Health Care ("DMHC") and by the California Department of Insurance ("DOI"). California law does not govern health coverage provided by entities that are not licensed in California or by employer-funded ERISA plans. The NSA will always apply to payments made to California providers by Commercial Payors not licensed in California and by employer-funded ERISA plans.

A) Out-of-Network Emergency Services

i) Claims for emergency services provided to members of DMHC regulated health plans.

Under California law, providers are precluded from balance billing members of health plans that are licensed by the DMHC who receive emergency services at an out-of-network hospital.[18] DMHC-regulated health plans are required to pay reasonable and customary value for emergency services provided to their members.[19] If a hospital is unhappy with the payment that the health plan makes, the hospital is entitled to utilize all its legal and equitable remedies, typically a lawsuit, to recover the quantum meruit value of the services rendered.[20]

The California law remedies for underpayments by DMHC-regulated health plans is clearly superior to the remedies

under the NSA for at least the following reasons:

- Under California law, a provider does not have to go through an IDR process and does not have to comply with the short time limitations for filing claims that are required under the federal IDR process.
- Under California law, all the provider's claims against a health plan can be raised in a single lawsuit, limited only by the statute of limitation. The federal IDR process contains cumbersome limitations on the bundling of claims in a single IDR proceeding.
- Under California law, the entire dispute between the provider and the health plan can be resolved in one proceeding. Under the NSA, the IDR process only resolves issues regarding the rate paid. It cannot resolve issues regarding down coding of claims and rejection of services as not medically necessary, not covered by the health plan, or other reasons for claim denials or reductions.
- Under California law, a court has discretion to allow wide ranging discovery into market conditions while the NSA allows no third-party discovery and requires limited exchange of information between the parties.
- Under California quantum meruit law, the court has discretion to allow a wide variety of evidence regarding the value of the services. This is a double-edged sword as the Health Plan may be allowed to offer evidence of Medicare and Medicaid rates (which cannot be considered under the NSA) but it allows the provider to offer a wider variety of evidence than is likely to be considered under the NSA.

ii) Claims for emergency services provided to insureds covered by DOI-regulated insurers.

California does not have a specified state law governing payments for out-of-network emergency services under health coverage provided by insurance companies so payments for those services will be governed by the NSA.

B) Services By Out-Of-Network Providers at In-Network Facilities.

California's AB 72[21] prohibits health insurers regulated by the DOI and health plans regulated by the DMHC from balance billing patients for services provided by out-of-network providers at in-network facilities.[22] It therefor supersedes the NSA for payments made by those entities. Thus, in California only payments made by out-of-state insurers or health plans, or by employer-funded ERISA plans are covered by the NSA.

AB 72 is like the NSA in that it requires an initial payment in the amount of the average payment that the Health Plan pays for similar in-network services, although the required methodology for calculating the average payment is different (AB 72 requires the initial payment to be based on the Health Plan's average payment, while the NSA focuses on the median payment). AB 72 also has an independent dispute resolution process that is somewhat like the NSA IDR process, but is a bit more flexible. For example, AB 72 requires the IDR entity to perform a de novo review to decide the appropriate rate. The IDR entity is not limited to deciding between the offers made by either party. And AB 72 provides that "If dissatisfied [with the IDR decision], either party may pursue any right, remedy, or penalty established under any other applicable law," while the NSA limits court review to the very limited review available for arbitration decisions.

4) Conclusion

The New Regulations cure the major defect in the interim final regulations by no longer providing that the QSA is presumptively correct. However, the NSA dispute resolution process is more cumbersome and limited than that provided by California law and will discourage health care providers from bringing meritorious claims.

Fortunately, the NSA is likely to have a relatively small impact in California because the largest volume of health coverage is provided by DMHC-regulated health plans which will remain governed by California law for both emergency medical services and for services provided by out-of-network providers in an in-network facility. In California, the NSA will only apply to: (1) claims for emergency services against DOI-licensed insurance companies; and (2) claims for emergency services and for out-of-network providers at an in-network facility against: (a) Commercial Payors not licensed by either the DOI or DMHC; and (b) employer funded-ERISA plans.

ENDNOTES

1 87 Fed. Reg. 52618.

2 The NSA does not apply to governmental health coverage, such as Medicare and Medicaid.

3 42 U.S.C. § 300gg-111.

4 42 U.S.C. § 300gg-111(a)(1).

5 42 U.S.C. § 300gg-111(b)(1).

6 42 U.S.C. § 300gg-111(c).

7 42 U.S.C. §§ 300gg-111(a)(3)(K) and (b)(1)(D).

8 45 C.F.R. § 149.110(b)(3)(iv)(A).

9 86 Fed. Reg. at 36900 -901 (July 13, 2001).

10 29 C.F.R § § 2590.716–6(d).

11 29 C.F.R § § 2590.716–6(c).

12 29 C.F.R § § 2590.716–6(d)(1)(iii).

13 29 C.F.R. § 2590.716-8(b)(2).

14 29 C.F.R. §§ 2590.716-8(b) and (c).

15 _____ Fed. Supp. 3d _____, 2022 WL 542879 (E.D. Tex., 2022).

16 2022 WL 1632580.

17 See, § 54.9816–8(c)(iii).

18 *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497, 507).

19 28 CCR § 1300.71(a)(3)(B).

20 Cal. Health & Saf. Code § 1371.25.

21 Cal. Health & Safety Code §§ 1371.9,1371.30 and 1371.31; Cal. Ins. Code § 10112.81.

22 AB 72 does not apply to emergency services.

GROSS MEANS GROSS FOR PERCENTAGE FEES

by **T. Mark Tubis**
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Mark Tubis represents health care providers and entities in their business transactions while advising on regulatory issues related to physician self-referral, anti-kickback law, the corporate practice of medicine doctrine, other federal and state fraud and abuse laws, and privacy and security laws. Mr. Tubis' clients include physician groups, sole practitioners, management services organizations, hospitals, telehealth companies, surgery centers, home health agencies, nonprofit organizations, dentists, med spas, clinics, and ancillary health care service providers.

In California, healthcare attorneys must grapple with the state's broad anti-kickback prohibition, even where its federal counterpart does not apply.[1] At issue are permissible compensation arrangements involving healthcare professionals for services other than the referral of patients. Business and Profressions Code section 650(b) says:

> The payment or receipt of consideration for services other than the referral of patients which is based on a percentage of gross revenue or similar type of contractual arrangement shall not be unlawful if the consideration is commensurate with the value of the services furnished or with the fair rental value of any premises or equipment leased or provided by the recipient to the payer.

Among healthcare attorneys, it is broadly understood that subsection 650(b) is not intended to prohibit all payment arrangements save for percentage of gross revenue. Rather, it codifies one permissible arrangement based on gross revenue or a similar arrangement for services other than referrals, as long as compensation is commensurate with the value of the services, space, or equipment received.

Yet, an issue remains over how "similar" a type of contractual arrangement must be to one based on a percentage of gross revenue. Some argue that compensation based on a percentage of net revenue (i.e., a profit split) [2] is permissible. Proponents of this interpretation point to the absence of any legislative clarification of subsection 650(b) or statutory language that explicitly prohibits contractual arrangements based on a percentage of profits. As a result, they argue that a compensation arrangement based on a percentage of net revenue is *sufficiently* similar under subsection 650(b) to compensation based on gross revenue. However, examinations of both the history of section 650 and multiple opinions by California's Office of the Attorney General ("AG") all indicate gross and net revenue are considered both materially and substantively different under section 650. To interpret otherwise and include a compensation arrangement based on a profit split is highly risky and unlikely to be compliant with California's anti-kickback statute.

The 1965 seminal case *Blank v. Palo Alto-Stanford Hospital Center*[3] considered the issue of net profits under section 650. At the time, the section prohibited "unearned" rebates and did not yet have the pertinent language regarding gross revenue contractual arrangements added by a 1990 legislative amendment. [4] *Blank* involved a contract between a hospital and radiologist partnership under which the hospital received two-thirds of the group's gross income collected as fees for the group's diagnostic services. In recognition of the costly nature of a hospital operation, the *Blank* court held the arrangement based on gross income was not illegal because apportionment of the fees was "commensurate with the expenses, direct and indirect, incurred by the hospital in connection with furnishing the diagnostic facilities."[5]

Essentially, the gross revenue split merely covered the hospital's costs as to its arrangement with the radiologist partnership.

Shortly thereafter, the AG relied on *Blank* in AG Opinion No. 81-605 in determining that an agreement under which a hospital received 50% of the net income earned by a physician director in the electroencephalography department was akin to a partnership or joint venture and violated section 650.[6] As the AG explained:

> There is nothing whatever in such arrangement which would indicate that the portion of fees received by the hospital would be commensurate with its own expenses incurred in connection with the furnishing of diagnostic facilities. On the contrary, the hospital's receipts are directly proportionate to the physician's profit factor, bearing no necessary relationship to its expenses.[7]

Whether the AG's conclusion about compensation based on a percentage of profits applies to all net profit arrangements or only those that do not approximate the fair market value of the services was put to rest ten years later. The AG unequivocally discussed in Opinion No. 81-605 how its 1972 opinion declared illegal "the payment of consideration based upon net income generated by referrals since that in effect would constitute a partnership or joint venture dividing profits based upon the amount of referral."[8] Through these opinions, the AG repeatedly distinguished net income from gross income as markedly dissimilar – thus unlawful – forms of consideration under section 650.

The AG's opinions and recognition of the material differences between gross and net income is consistent with the substantively different treatment of gross and net revenue in other settings such as accounting, litigation, and taxation. [9] Further, profit-sharing also, to the extent it creates a partnership (if only implied), violates California's corporate practice of medicine ban if one of the parties is unlicensed.[10]

However, in 1989, the appellate court overruled *Blank* in *Beck v. American Health Group Internat., Inc*.[11] The court held that an arrangement violated section 650 where a psychiatric doctor would receive ten percent of gross revenue for room and board.[12] This resulted from a prior amendment to section 650 that removed the word "unearned" before "rebate," which the court reasoned showed legislative intent to prohibit any compensation arrangement subject to increase by the referral of patients. [13] The legislature quickly stepped in and amended section 650 the next year to add the *Blank* exception regarding compensation arrangements based on gross revenue. In doing so, *Blank* and the related AG opinions were again good law.

There is no basis in California law for the assertion, sometimes advanced, that net revenue (or profit) is "similar" to gross revenue. Thus, any arrangement subject to section 650 that calls for a percentage of net revenue, versus gross revenue, is highly risky and likely unlawful.

ENDNOTES

1 *See* Bus. & Prof. Code § 650(a), which states in pertinent part, "[T]he offer, delivery, receipt, or acceptance by [applicable licensees] of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person . . . is unlawful."

2 *See Bailey v. Outdoor Media Group* (2007) 155 Cal.App.4th 778, 788 [66 Cal. Rptr.3d 322, 330]. For the purpose of this article, just as some courts tend to, net income and net revenue are treated interchangeably. (*See, e.g., Phillips, Spallas & Angstadt, LLP v. Fotouhi* (2011) 197 Cal. App.4th 1132, 1144 [128 Cal.Rptr.3d 320, 330]; *American Toll Bridge Co. v. Railroad Commission* (1938) 12 Cal.2d 184, 206 [83 P.2d 1, 11], *aff'd sub nom. American Toll Bridge Co. v. Railroad Commission of California* (1939) 307 U.S. 486 [59 S.Ct. 948, 83 L.Ed. 1414].)

3 *Blank v. Palo Alto-Stanford Hospital Center* (1965) 234 Cal.App.2d 377 [44 Cal.Rptr. 572].

4 *See* Stats. 1990, ch. 1532 (S.B. 2365), § 1.

5 *Id.* at 390 [44 Cal.Rptr. 572, 580].

6 55 Ops.Cal.Atty.Gen. 107, 108 (1972)

7 *Ibid.*

8 *See* 65 Ops.Cal.Atty.Gen. 252 (1982) (emphasis in original).

9 Net profits are the gains made from sales after deducting the value of the labor, materials, rents, and all expenses, together with the interest of the capital employed. (*See Gerwin v. Southeastern Cal. Assn. of Seventh Day Adventists* (1971) 14 Cal.App.3d 209, 223 [92 Cal.Rptr. 111, 119–120].) Gross profits, on the other hand, "are really not profits at all, because they generally refer to the excess in the selling price over the cost price, without a deduction of the expenses of resale and other costs involved in doing business." (*See* 23 Cal. Jur. 3d Damages § 92.) The difference in effect between a tax measured by gross receipts and one measured by net income "is manifest and substantial, and it affords a convenient and workable basis of distinction between a direct and immediate burden upon the business affected and a

charge that is only indirect and incidental." (*Matson Nav. Co. v. State Bd. of Equalization of Cal.* (1935) 3 Cal.2d 1, 9 [43 P.2d 805, 809], *aff'd sub nom. Matson Nav. Co. v. State Bd. of Equalization of State of Cal.* (1936) 297 U.S. 441 [56 S.Ct. 553, 80 L.Ed. 791].) A plaintiff seeking lost business profits must show loss of net profits, not just loss of gross revenue. (*Kids' Universe v. In2Labs* (2002) 95 Cal. App.4th 870, 884 [116 Cal.Rptr.2d 158, 169].)

10 The Supreme Court explained that profit-sharing is prima facie evidence of a partnership except where received in payment as wages of an employee. (*Nelson v. Abraham* (1947) 29 Cal.2d 745, 750 [177 P.2d 931, 933].) Under the corporate practice of medicine doctrine, only duly-licensed physicians and professional medical corporations (which may be owned by physicians together with certain other licensed professionals) may practice medicine. Thus, the debate over compensation arrangements under section 650 is moot where the parties are restricted from being partners in the entity of which profits are split.

11 *Beck v. American Health Group Internat., Inc*. (1989) 211 Cal.App.3d 1555, 1564 [260 Cal.Rptr. 237, 243].

12 *Id.* at 1564-1565 [260 Cal.Rptr. 237, 243].

13 *Id.* at 1565 [260 Cal.Rptr. 237, 243–244].

MEDICAL SPA TOOLKIT

by **Matthew Stokke**
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Matthew Stokke is senior associate at Cohen Healthcare Law Group. His broad practice includes representing healthcare practices and management services organizations, providing FDA and FTC regulatory counsel to health and wellness and life sciences companies, structuring healthcare transactions ranging from traditional brick-and-mortar to connected care settings, and advising complementary and alternative healthcare providers. Mr. Stokke earned his J.D. from Loyola Law School in 2013 and was chair of the Orange County Bar Association's Healthcare Law section in 2021.

Medical spa legal issues continue to come into focus just as the beauty industry continues its steady growth in the health and wellness market. Since the explosion of medical spas some time ago now, variations of these practices, such as IV hydration clinics, have begun their own expansion into the industry. What is clear is that consumer demand for these minimally invasive beauty and wellness services will only continue to grow at dizzying rates, according to current market research and projections. As such, these practices have garnered significant attention and enforcement actions over the years from the California Medical Board. Healthcare lawyers representing medical spas must be sure to properly educate and advise these clients, as there is too much for these licensed professionals to lose. This toolkit article addresses some common day-to-day healthcare law issues faced by medical spa clients on a high-level. Unique client situations may call for a more nuanced analysis made by a capable healthcare law attorney.

Question: Who can own a medical spa?

Since medical services are provided, medical spas must be set up as California medical corporations and abide by the same ownership restrictions affecting conventional medical practices. Pursuant to California Corporations Code section 13401.5, certain non-physician licensees (registered nurses, physician assistants, etc.) may be shareholders, officers, directors, or professional employees of a medical corporation, "so long as the sum of all shares owned by those licensed persons does not exceed 49 percent of the total number of shares of the [medical] corporation..." Additionally, the *number* of non-physician licensee owners cannot exceed the number of physician owners in the medical corporation.

Many mid-level providers such as nurses and physician assistants will book a consultation with a healthcare attorney to talk about their new medical spa business idea, into which they've already poured hours of blood, sweat, and tears. When the fundamental topic of ownership restrictions arises, they are discouraged to find out they must hand over 51% of their dream to an oftentimes unknown physician, who is legally required to be the majority co-owner of a medical spa in California. Many times, these individuals were not aware such restrictions existed. Some might have assumed they could own their own professional nurse or physician assistant corporations and simply contract with a non-owner "medical director" to provide physician supervision services and medical director services, as needed, to their own practices.

In addition to practice autonomy prohibitions, the Medical Board of California, in its "Practice Information" website publication (https://www.mbc.ca.gov/Licensing/Physicians-and-Surgeons/Practice-Information/), lists examples of corporate practice of medicine violations, one of which is described as follows: "A physician acting as 'medical director' when the physician does not own a practice. For example, a business offering

spa treatments that include medical procedures such as Botox injections, laser hair removal, and medical microdermabrasion, that contracts with or hires a physician as its 'medical director.'" Informally known as a "doc-in-a-box" arrangement where a physician effectively "rents" his or her medical license to the medical spa for a fee, the Medical Board goes on to state that in such an example, "non-physicians would be engaged in the unlicensed practice of medicine and the physician may be aiding and abetting the unlicensed practice of medicine." Such allegations could potentially trigger criminal penalties under California Business and Professions Code section 2052.

Accordingly, the medical spa must be set up as a California medical corporation. A mid-level provider such as a registered nurse or physician assistant may hold up to 49% ownership in such practice. Like any conventional medical practice, the medical spa must hire and establish payroll for all professional service providers, obtain malpractice and other insurance policies, and assume the normal liabilities of a conventional medical practice.

Some clients, namely the mid-level provider client, find only frustration when legal advice like this is given, and inevitably point to what is happening "in the real world". Likewise, some physicians believe they can assume the role of "medical director" (a title frowned upon by the Medical Board) without having to set up a medical corporation, establish payroll, and obtain appropriate insurance for operational liabilities. It is worth mentioning to these clients that the Medical Board has historically taken non-compliance in the medical spa arena very seriously and has initiated enforcement actions. Moreover, because competition is so fierce in this industry, it is not uncommon for industry participants to file Board complaints or initiate legal actions against each other for these reasons.

Q: How involved should the owner-physician be in a medical spa?

Physicians must first and foremost follow their professional laws and regulations governing physician supervision of mid-level providers. When the Medical Board began prioritizing enforcement in the medical spa arena years ago, the Board published an advisement, which is still available online, named, "The Bottom Line: The Business of Medicine – Medical Spas". The advisement defines and clarifies a physician's supervision requirements in the medical spa context specifically. Among other things, physicians must conduct the initial examinations of patients (known as the "good faith exam") prior to delegating permitted medical spa services to mid-level providers pursuant to written standardized procedures and delegation of services agreements. While registered nurses may not perform these good faith exams, nurse practitioners and physician assistants may provide these initial examinations pursuant to their advance licensure. Though note, importantly, that neither a nurse practitioner nor a physician assistant is authorized by law to delegate medical spa procedures to a registered nurse. Presumably, these good faith exams of patients for medical spa procedures could potentially be performed via telehealth technology pursuant to California Business and Professions Code section 2242 if the licensee complies with the appropriate standard of care. However, the general "best practice" recommendation is to conduct the good faith exams in person to help support professional standard of care and reduce risk of a patient's misperception of impropriety.

Though the physical presence of a physician is not explicitly required while a registered nurse or other mid-level provider renders delegated medical spa procedures under standardized procedures, the Medical Board's general advisement for supervising physicians is to be "immediately reachable" and to actually supervise by directing, overseeing, inspecting, and evaluating performance. In other words, supervision only on paper is just an expensive piece of paper -- it is not enough. Similarly, the Medical Board emphasizes the importance of the supervising physician's competence in the procedures he or she is delegating. Certifications and sufficient hands-on experience with aesthetic medicine procedures may help support adequate supervision.

Q: What are some common operational risk mitigation strategies lawyers can address with medical spa clients?

- Develop and circulate appropriate professional staff policies to ensure adequate medical records are prepared and maintained for each patient visit. Not only is such

documentation required under professional board regulations, but it may help support standard of care and help defend against patient complaints, which can be frequent in these practices.

- The medical corporation should circulate copies of the most updated procedures and protocols approved by the physician to the office regularly and require all professional service providers to sign these.
- The medical corporation should circulate a helpful Medical Board publication clarifying who can provide common medical spa procedures: https://www.mbc.ca.gov/FAQs/?cat=Licensees&topic=Cosmetic%20Treatments
- Circulate an employee manual referencing professional regulations affecting the marketing of medical spas. Many medical spa employees will use social media to promote the medical spa in good faith, but will unintentionally post protected health information of patients, such as "before and after" photos. Not only are there obvious HIPAA and privacy issues, but the professional advertising regulations set forth specific requirements and limitations for marketing claims and visual content.
- Appropriate clinical personnel should perform a good faith exam of each patient at least annually, and more often as clinically needed, to account for a patient's new allergies, prescribed medications, dietary supplement regimens, recent surgeries, pregnancy, and other new courses of care their primary care provider has recommended since the last examination.
- The physician's photos should be published on the medical spa's website and posted in the practice site with those of other clinical personnel.
- Medical procedures should not be provided in any room where non-medical procedures occur, such as aesthetician services.

APPELLATE CASE SUMMARIES

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Medical malpractice claim for a child's still birth does not accrue when autopsy fails to determine cause of death

Kernan v. Regents of the University of California (Aug. 29, 2022, A162750) __ Cal.App.5th __ [2022 WL 4363156], ordered published Sept. 20, 2022

Charlotte Kernan underwent an apparently successful prenatal procedure to rotate her fetus from the breach position. She returned to the hospital the next day because she could not detect fetal movement. Doctors determined she had suffered an intrauterine fetal demise (IUFD) and informed her that its cause is often unknown. At the time of her child's still birth, no medical literature linked the prenatal procedure with IUFD and the delivery doctor could identify no cause of death. Kernan later ordered an autopsy. For months, Kernan's delivery doctor failed to respond to her requests to review the autopsy report. She finally consulted a different doctor, who informed her that the hospital had initiated a morbidity and mortality conference regarding her case, but refused to tell her what was said at that conference. This triggered Kernan's suspicion that medical negligence caused her baby's death, and she filed suit against the hospital within one year. The hospital moved for summary judgment, arguing the action was time-barred under Code of Civil Procedure section 340.5(2) because it accrued when she was informed about the IUFD and ordered the autopsy. The trial court granted the motion and Kernan appealed.

The Court of Appeal reversed, holding there was a triable issue of fact whether Kernan subjectively and objectively suspected medical malpractice on the date she learned of the IUFD. Because doctors told Kernan that the cause of her IUFD was unknown, she continued seeking care and requested an autopsy. A reasonable trier of fact could conclude she did not, at that juncture, subjectively suspect medical negligence. Likewise, reasonable minds could differ regarding whether Kernan objectively should have suspected malpractice when her doctors said they did not know the cause of death, there was no known association between her prenatal procedure and IUF, and the autopsy report found no specific cause of death.

The litigation privilege entitled hospital to anti-SLAPP dismissal of physician's claims arising out of peer review proceedings

Bonni v. St. Joseph Health System (Aug. 23, 2022, G052367) __ Cal. App.5th __ [2022 WL 4232964]

Invoking Health and Safety Code section 1278.5, Dr. Aram Bonni filed a whistleblower lawsuit against two hospitals where he had admitting privileges alleging they retaliated for his complaints about patient safety by suspending his privileges and initiating peer review proceedings. The hospitals filed an anti-SLAPP motion, arguing that Dr. Bonni's claim arose from protected peer review proceedings and had no merit. The trial court granted the motion and Dr. Bonni appealed. The California Supreme Court ultimately granted review and held

that Dr. Bonni's retaliation action was composed 19 distinct claims, of which eight arose from protected activity. The Court remanded the case to the Court of Appeal to determine whether Dr. Bonni had established a probability of prevailing on the merits of those eight claims.

The Court of Appeal held that Dr. Bonni failed to show that any of the eight claims had merit since all of them were precluded by the litigation privilege. (See Civil Code, § 47.) The litigation privilege provide absolute protection for communications made in connection with official judicial or quasi-judicial proceedings, including medical peer review proceedings. The eight claims identified by the Supreme Court covered three categories of conduct: (1) the reporting of Dr. Bonni's suspension to the medical board, (2) the peer review proceedings, and (3) one hospital's settlement negotiations. Regarding the reports, the appellate court rejected Dr. Bonni's argument that his claim was based on noncommunicative acts because the hospital engaged in inherently communicative acts when making the statutorily required reports. Next, the court held that the hospitals' initiation of peer review proceedings, like the filing of a lawsuit, is a protected communication distinct from the act of suspending privileges. Similarly, Dr. Bonni's claims based on statements made during peer review were part of an official proceeding. Finally, the court held that Dr. Bonni's tort claims based on settlement negotiations were barred by the litigation privilege regardless whether he might bring a separate equitable action to rescind the settlement agreement.

Ambulance company owed a general duty of care to a patient who jumped out of a moving ambulance while being transported

T.L. v. City Ambulance of Eureka, Inc. (Sept. 29, 2022, A162508) __ Cal. App.5th __ [2022 WL 4544295]

T.L., a minor, was admitted to a crisis stabilization unit where a clinician placed her on a 72-hour mental health hold under the Welfare and Institutions Code. The following day, T.L.'s attending psychiatrist determined that she was stable and could be safely transferred to an in-patient facility where she could receive a higher level of care. The psychiatrist decided not to prescribe specific transfer protocols, such as a sedative or safety restraints. Discharge nurses advised the paramedics and the EMT staffing the transfer ambulance that T.L. was on a mental health hold, but that she was calm, cooperative, and stable for transfer. Ambulance personnel reviewed T.L.'s medical records and saw no behavioral problems warranting the use of restraints. They placed T.L. on a gurney and buckled her in to the ambulance with two safety belts. Fifteen minutes into the transport, and without warning, T.L. unbuckled both belts and stepped out of the back of the moving ambulance, suffering serious injuries. T.L. sued the ambulance company for negligence. It moved for summary judgment on the ground that, under *Hernandez v. KWPH Enterprises* (2004) 116 Cal.App.4th 170, it owed no duty to prevent T.L. from engaging in "impulsive, reckless, irrational and self-harming conduct." The trial court granted the motion, concluding *Hernandez* was dispositive, and T.L. appealed.

The Court of Appeal reversed. The court distinguished *Hernandez*, which involved a patient who had entered an ambulance voluntarily and then ran away after arriving at the hospital, and who was later struck by a car while crossing a road. By comparison, T.L. was being transferred involuntarily from one facility to another, and was injured during transport, rather than after arrival. The court rejected the defendants' argument that they had no duty to protect T.L. from unilaterally and unexpectedly unbuckling the belts and stepping out of the ambulance. To the contrary, the trained and licensed paraprofessionals providing a medical transportation services owed T.L. a general duty to act with due care based on their special relationship with her. The court further determined that the *Rowland* factors did not warrant a departure from a general duty to use reasonable care to protect T.L. during transport. The court did not hold that ambulance personnel acted negligently, or that they had a duty to restrain T.L. because she was on a mental health hold. The court only held that they had a duty to use reasonable care under the circumstances (such as equipping the gurney with a shoulder harness, and/or locking the rear door of the ambulance) to ensure safe transport.

Negligently performing an MRI scan does not substantiate an elder abuse claim

Kruthanooch v. Glendale Adventist

Medical Center (Oct. 4, 2022, B306423) __ Cal.App.5th __, 2022 WL 5126799

Daniel Kruthanooch, an elderly man, presented to Glendale Adventist Medical Center (GAMC) after experiencing weakness. A GAMC doctor ordered an electrocardiogram (EGC) and an MRI. A GAMC technologist failed to remove the EGC pads prior to the MRI, resulting in burns to Kruthanooch's abdomen following the scan. Kruthanooch sued GAMC for professional negligence, elder abuse, and elder abuse per se. When he died, his estate was substituted in his place and abandoned all claims other than elder abuse. A jury found GAMC liable for elder abuse, but awarded no damages. The trial court then granted GAMC's motion for JNOV, ruling there was no substantial evidence that GAMC had care or custody of Kruthanooch, or that it acted with neglect or recklessness. The estate appealed.

The Court of Appeal affirmed. First, the court held the estate fail to present substantial evidence that GAMC had a robust caretaking or custodial relationship with Kruthanooch required to establish a custodial relationship under the Elder Abuse Act, as construed by *Winn v. Pioneer Medical Group, Inc.* (2016) 63 Cal.4th 148. The court explained that the heightened remedies provided under the Act are available only when the defendant has "ongoing responsibility for one or more basic needs" of an elderly patient. Although GAMC admitted Kruthanooch for in-patient care and provided him with mobility and hydration assistance, that did not mean GAMC assumed a robust caretaking or custodial relationship where Kruthanooch was cognitively aware; capable of making his own medical decisions; and present at GAMC for only a few hours prior to his injury. Second, the court found no substantial evidence of neglect. The court explained that neglect refers not to the provision of substandard care, but instead to a caregiver's failure to provide for the basic needs and comfort of an elder or dependent adult. While GAMC's failure to screen Kruthanooch for EGC pads could support a finding of professional negligence based on the estate's expert standard of care evidence, it was not evidence of neglect under the Act (i.e., the failure to provide ***any*** medical care or attend to a patient's basic needs).

Breach of confidentiality claim under the CMIA requires proof that medical information was "actually viewed" by an unauthorized party

Vigil v. Muir Medical Group IPA, Inc. (Sept. 26, 2022, A160897) __ Cal. App.5th __ [2022 WL 10239738], ordered published Oct. 18, 2022

A former Muir Medical Group employee downloaded and retained the private medical information of over 5,000 patients. Muir patient Maria Vigil filed a class action complaint against Muir alleging violations of the Confidentiality of Medical Information Act (CMIA) (Civ. Code, §§ 56 et seq.) and seeking statutory damages for each class member. The trial court denied Vigil's motion for class certification, ruling that common issues would not predominate because, under *Sutter Health v. Superior Court* (2014) 227 Cal.App.4th 1546, each class member would need to show that his or her confidential information was "actually viewed" by an unauthorized party to obtain CMIA remedies. Vigil appealed.

The Court of Appeal affirmed. Agreeing with *Sutter Health*, the court explained that negligently losing possession of confidential medical information does not, by itself, establish a breach of confidentiality under the CMIA. More is required—proof that the information was *actually viewed* by an unauthorized party—because the CMIA's focus is medical information, not physical records. This construction of the CMIA advances its purpose to protect patient privacy while accommodating common law negligence principles, which require proof of causation and injury beyond the mere breach of a duty. Because the potential for an unauthorized party to access confidential information does not establish a CMIA claim, Vigil had to show that actual unauthorized viewing of patient medical information could be established on a class-wide basis. She failed to do so, therefore the trial court did not abuse its discretion when it ruled that individual issues would predominate over common issues. While the record showed that the former employee may have viewed some of the purloined medical information, each class member's right to recover under the CMIA depended on the facts of his or her individual circumstances.

Hospital immune from civil liability for reporting to National Practitioner Data Bank that doctor surrendered privileges while under investigation

Wisner v. Dignity Health (Oct. 18, 2022, C094051) __ Cal.App.5th __

[2022 WL 16706648], certified for partial publication Nov. 4, 2022.

Dr. Gary Wisner was criminally charged with making false insurance claims. The Medical Board of California also issued an accusation seeking to revoke or suspend his license for gross negligence and repeated negligent treatment of multiple patients. Six months later, Dr. Wisner asked Dignity Health St. Joseph's Medical Center (SJMC) to place him on its on-call panel. He held courtesy staff privileges at SJMC, but had not treated patients there for two decades. SJMC's chief of staff "began an investigation" and asked Dr. Wisner for all available information about the accusation and the indictment. The chief of staff explained that SJMC needed to independently review the evidence to assess the validity and peer review implications of the charges. Dr. Wisner told SJMC he had no additional information to provide, asserted that he was "clearly" not under investigation at SJMC, and "resign[ed] all privileges." SJMC filed a statutorily mandated report with the National Practitioner Data Bank (NPDB) that Dr. Wisner had surrendered his clinical privileges while under investigation. Dr. Wisner responded by asserting the NPDB report was false and asking the Secretary of the Department of Health and Human Services to review its accuracy. He also sued SJMC for fraud, defamation, and other claims. In the administrative proceeding, the Secretary rejected Dr. Wisner's challenge, finding no basis for Dr. Wisner's claim that the report should not have been filed or that it was inaccurate, incomplete, untimely, or irrelevant. In the civil action, the trial court granted SJMC's anti-SLAPP motion. Dr. Wisner appealed.

The Court of Appeal affirmed. Dr. Wisner conceded that filing an NPDB report is a protected activity, but argued that some of his claims arose from unprotected activity, such as SJMC's refusal to place him on its call panel, and SJMC's demand that he exercise his prehearing discovery rights in the Medical Board's administrative proceeding and provide that discovery to SJMC. The Court of Appeal held that Dr. Wisner forfeited this contention by failing to raise it in the trial court. The Court of Appeal agreed with the trial court that Dr. Wisner could not meet his burden under the anti-SLAPP statute to demonstrate a probability of prevailing on the merits. Under the Health Care Quality Improvement Act (42 U.S.C. § 11101 et seq.), SJMC was immune from liability for making a mandatory NPDB report when a physician surrendered privileges while under investigation. The court rejected Dr. Wisner's contentions that the meaning of the term "investigation" was a jury question, and that the term should be narrowly construed to mean a formal investigation pursuant to hospital bylaws. Rather, the statutory term had to be construed by the court as a matter of law. Relying on the NPDB Guidebook's broad definition, the court held that an "investigation" commences as soon as there is a focused "inquiry" into potential misconduct, and therefore the undisputed evidence established that Dr. Wisner was "under investigation" when he resigned. The court explained that allowing hospital bylaws to control the statutory definition of "investigation" would result in ad hoc and inconsistent reporting by health care entities across the nation, thwarting the purpose of the reporting requirement.

Plaintiffs may withdraw from arbitration if hospital doesn't timely pay arbitration fees

Williams v. West Coast Hospitals, Inc. (Dec. 22, 2022, H049177) __ Cal. App.5th __ [2022 WL 17881773]

Ann Williams was admitted to a West Coast Hospital center to recover from hip surgery. West Coast discharged her to an assisted living facility where she died five days later. Williams' son (and other family members) sued West Coast for elder abuse and wrongful death, alleging that its failure to nourish and hydrate Williams cause fatal renal failure. The trial court granted West Coast's motion to compel arbitration, which stayed the litigation, but West Coast then failed to pay its arbitration filing fee on time. Plaintiffs moved for an order vacating the litigation stay based on their election to withdraw from arbitration under Code of Civil Procedure sections 1281.97 and 1281.98 (because West Coast had not timely paid arbitration fees). Although West Coast belatedly paid its fees, the trial court granted the motion. West Coast appealed.

The Court of Appeal affirmed. First, the court rejected West Coast's argument that withdrawal was not permitted until the arbitrator found the drafting party was in default. The court held instead that the statutes empower consumers who are

parties to arbitration agreements to *unilaterally withdraw* from arbitration upon the drafting party's failure to pay required fees. The court also rejected West Coast's argument that the trial court lacked jurisdiction to vacate its own stay order, explaining that the trial court's vestigial jurisdiction over the action at law allowed it to vacate the litigation stay once plaintiffs withdrew from the arbitration. Finally, the court refused to draw a distinction between voluntary and mandatory arbitration agreements, holding the withdrawal statutes applied equally to both.

Preservation letter is not notice of intent to sue under CCP § 364; confidential mental health records are sometimes admissible

McGovern v. BHC Fremont Hospital, Inc. (Dec. 21, 2022, A161051) __ Cal. App.5th __ [2022 WL 17828959], ordered published Jan. 4, 2023

On November 7, 2015, Shannon McGovern was attacked and injured by a fellow patient at BHC Fremont Hospital, Inc. Her counsel sent Fremont a letter on March 9, 2016 stating McGovern had "serious" injuries "to her head, and back, including a broken clavicle," requesting the hospital preserve evidence, and stating that counsel was gathering information to present a prelitigation demand to the hospital's insurance carrier. On October 27, 2016, McGovern's counsel sent Fremont a "Notice of Intent to Commence Action for Medical Negligence Pursuant to Code of Civil Procedure [section] 364" detailing her specific injuries. McGovern sued Fremont on January 20, 2017, and demanded discovery of Fremont's mental health records for the patient who attacked her. Fremont moved to quash and for summary adjudication of McGovern's professional negligence claims under MICRA's 1-year statute of limitation (Code. Civ. Proc., § 340.5), arguing that the March 9 letter constituted a notice of intent to sue, so the October 27 letter failed to toll the limitations period. The trial court granted both motions, and later granted Fremont's motion for summary judgment. McGovern appealed.

The Court of Appeal reversed. First, the court held that McGovern's March 9 letter was not a notice of intent to sue under section 364, so her later October 27 notice tolled the limitations period. The court explained that the March 9 letter did "not state, nor even imply, that [plaintiff] was giving 'notice of her intention to commence [an] action.' " Instead, the bulk of plaintiff's letter regarded preserving evidence, and it only mentioned a future prelitigation demand in hopes of *avoiding* litigation. A threat of *potential* litigation is insufficient to give notice under section 364. The March 9 letter also failed to meet section 364's requirement to state "with specificity the nature of the injuries suffered;" it contained only generalized statements regarding McGovern's injuries, not "treatment, sequelae, or residual injury," or any amount of economic or noneconomic losses.

The trial court also erred by quashing discovery of the attacker's mental health records based on a mistaken belief such records are always inadmissible. Although the discovery implicated patient privacy concerns, a statute permits the use of confidential patient records in litigation " 'as necessary to the administration of justice.' " (Welf. & Inst. Code, § 5328, subd. (a)(6).) The psychotherapist-patient privilege (Evid. Code, § 1014) likewise does not always bar disclosure since it can be waived or subject an exception, such as when a patient presents a serious danger to others (Evid. Code, § 1024). Thus, the trial court was required to reconsider the motion on remand.

Medical malpractice plaintiffs lack standing to seek declaratory relief challenging MICRA's constitutionality

Dominguez v. Bonta (F082053 & F082208, Dec. 19, 2022) __ Cal. App.5th ___ [2022 WL 17752246], ordered published Jan. 6, 2023

Heirs of deceased patients sued healthcare professionals for medical malpractice and filed this declaratory relief action against the California Attorney General challenging the constitutionality of two pre-A.B. 35 MICRA statutes: (a) Civil Code section 3333.2, which caps noneconomic damages in professional negligence actions against health care providers; and (b) Business & Professions Code section 6146, which limits attorneys' contingent fees in such actions. The heirs alleged that it was infeasible for their law firm to represent them due to the damages cap and contingent-fee limitation, and that the insurance crisis that precipitated MICRA has been alleviated. They pleaded violations of their right to petition the government and the takings, equal protection, due process, and jury trial provisions in both the federal and statute constitutions. The

trial court sustained the Attorney General's demurrer without leave to amend, ruling the heirs lacked standing. The heirs appealed.

The Court of Appeal affirmed. After explaining how the MICRA statutes have been repeatedly upheld against constitutional challenges by both the Supreme Court and Courts of Appeal, the court held the heirs lacked standing to challenge the constitutionality of MICRA. The "potential that heirs may ultimately have to prosecute their medical malpractice case in propria persona in the event their current medical malpractice counsel withdraws does not rise to the level of a cognizable injury for standing purposes." Accordingly, the "heirs' alleged injuries are neither concrete nor actual. They are, at present, conjectural and hypothetical." For the same reason, there is no basis for concluding that the heirs will suffer hardship if declaratory relief is withheld. The litigants' mere "difference of opinion" as to the validity of MICRA statutes "is obviously not enough by itself to constitute an actual controversy" within the meaning of California's declaratory relief statute. (Code Civ. Proc., § 1060.)

GETTING TO KNOW... JEREMY AVILA

Jeremy Avila
California Department of Aging

Jeremy Avila is the Chief Counsel of the California Department of Aging (CDA), a position he has held since March 2021. As Chief Counsel, Jeremy serves as the head legal officer for CDA and leads an in-house legal team that advises on a wide range of government and healthcare related matters.

1. Where are you currently employed and what is your position?

I am the Chief Counsel for the California Department of Aging.

2. How long have you held that position?

Since March, 2021.

3. When did you become a member of CSHA?

In 2021.

4. Why are you a member of CSHA?

My friend and colleague, John Puente, encouraged me to join. After learning about the organization, I decided to join because it was a great source of information and education for my new role with the State.

5. Did you practice in any other area of law before you became a health lawyer, and if so, what area?

I started my career as a Deputy District Attorney for Monterey and Santa Clara counties, respectively. During this time, I first-chaired nearly 30 trials and handled a wide range of criminal prosecutions and investigations, including complex domestic and international drug trafficking. I later joined the Office of the County Counsel for Santa Clara County, where I performed a mix of civil enforcement, civil litigation, and government advice work.

6. What is your health law sub-specialty and why did you choose it?

The healthcare-facing component of my work has a strong emphasis on long-term care, connecting older adults to healthcare, and home and community-based Medi-Cal waiver services for older and disabled adults.

7. What is the biggest challenge in your job?

As Chief Counsel, I lead our in-house legal team and provide general legal support to the Department and its principals. This oftentimes means leaning in and advising on day-to-day operations (e.g., labor & employment, government contracting, compliance with Medi-Cal certification standards, etc.) or expansion into new program areas for the older adults, disabled adults, and family caregivers that we serve.

The biggest challenges include tracking and guiding the many aspects of the Department's emerging work with our governmental, non-profit, and for-profit partners, and anticipating the legal needs and challenges that a statewide entity faces from both an internal operations and an external service delivery perspective.

8. Describe an excellent day at the office for you.

An excellent day consists of providing timely and top-notch legal guidance to our Department, or the opportunity to learn something new in pursuit of that goal. I'm lucky to say that most days are "excellent" ones.

9. What is/was your worst moment as a lawyer?

Failing the California bar exam. I fell short by a handful points and feared that my legal career would be over before it even began. I sat for the exam a second time and passed.

10. What do you consider your greatest achievement in your career?

I had the privilege of playing

a leading role in Santa Clara County's local response to the COVID-19 pandemic by helping rent burdened tenants stay in their homes. Navigating complex and novel issues of federal and state constitutional and statutory law to keep people housed and help prevent the spread of COVID-19 against the backdrop of those hectic early days of the pandemic was an experience that I will never forget.

11. What do you think is the biggest challenge the health care system faces today?

Making comprehensive care more affordable and putting it within reach so that we as a society do not suffer the consequences of a lack of or insufficient access to care.

12. What goals do you have for the future, both career and personal?

Serving as Chief Counsel of a state-level department and leading our team have been humbling and rewarding experiences. I hope to build a top notch team and structure that will serve this Department and the millions of people who rely on us. Beyond that, I look forward to professional opportunities and challenges that leverage and call upon my experience and perspective as an advocate, government lawyer, and leader. On the personal side, I hope to always be the kind of person that my loved ones can take pride in.

13. What hobbies do you pursue?

I love to cook, hike, and play with my adorable (but exhausting) puppy.

14. What is your motto?

Do or do not. There is no try. - Yoda

15. What words of wisdom – about anything – would you want to pass on? OR: What's one piece of advice you remember most clearly?

Life is short and careers are long. It's rarely "too late," so don't limit yourself, and always be on the lookout for how you can learn and grow.

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