CALIFORNIA HEALTH LAW NEWS

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CALIFORNIA HEALTH LAW NEWS

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

Carla J. Hartley

Katherine Broderick

Dear Readers:

This Winter 24 edition of *California Health Law News* is filled with interesting and timely California specific health law news.

In this issue we feature an article by Rebecca Wicks discussing the bankruptcy case of Borrego Community Health Foundation ("Borrego") which was precipitated by the California Department of Health Care Services threatening to suspend Medi-Cal payments to Borrego. The second article by Bailey Bifoss, Parnian Vafaeenia, Jonathan L. Brophy discussing SB 525 which will institute a minimum wage for healthcare workers beginning June 2024. The article by Shari Covington analyzes the impact of SB 815, which, among other things, requires medical board investigators to interview patients or their families before closing a complaint, establishes a complaint liaison, and provides that a conviction of a "serious felony" by a physician, including the sale or transfer of fentanyl will result in automatic license suspension. We also have Sheirin Ghoddoucy featured in our Getting to Know series who has now been with California Medical Association for over a year and is a new member of the Publications Committee.

The Publications Committee is hoping to continue with the Criminalization of Healthcare Series that discusses the impact of laws which criminalize patients and providers for seeking and delivering healthcare. This is especially important while we wade through the mountain of issues ourselves and our clients are forced to deal with in a post *Dobbs* world. In addition to the Criminalization of Healthcare Series the Publications Committee is considering starting AI in Healthcare Series that will discuss the various legal impacts AI can have in the healthcare setting.

In an effort to limit the amount of emails our members receive and to consolidate all the information we want our members to see in one source, CSHA has been issuing *The Weekly* every Tuesday via email. *The Weekly* features the following sections: Featured News; Watching; Member News; Litigation Update; Job Board; and Upcoming Events. On a rotating basis, members on the Publications Committee draft the Watching section, which is a brief post on California healthcare legal issues of interest.

As always, if you have any ideas or would like to author anything for the Watching in *The Weekly* or articles in *California Health Law News* or have suggestions for the Publication's Committee please reach out to Carla or myself at cjh@dillinghammurphy.com or kate.broderick@commonspirit.com.

From all of us on the Publications Committee, we hope you all had a restful holiday season and wish all of you a happy new year!

Kate Broderick

ANNOUNCEMENTS

ROOM BLOCK OPEN: 2024 ANNUAL MEETING AND SPRING SEMINAR

The room block is open for the California Society for Healthcare Attorneys (CSHA) 2024 Annual Meeting & Spring Seminar, scheduled for May 3-5, 2024, at the Everline Resort & Spa in Olympic Valley. Join us for a captivating event featuring a full day of MCLE presentations on Friday, with mornings only on Saturday and Sunday, allowing afternoons free for you and your family to explore the beautiful Lake Tahoe area. And that's not all – the Friday evening Welcome Reception and the Saturday evening Annual Dinner, complete with entertainment, offer prime opportunities for networking with your health law peers.

To secure your accommodations at the Everline Resort and Spa, we've set up a dedicated booking website for our conference. Click here to make, modify, and cancel your hotel reservations online. Alternatively, you may call the hotel directly at (800) 404-8006 and ask for the 2024 CSHA spring seminar group rate.

Room Rates for the 2024 Seminar (if booked by April 4, limited availability):

- Deluxe Guest Room: $259.00 plus resort fees and taxes
- Fireplace Suite: $309.00 plus resort fees and taxes
- Deluxe Fireplace Suite: $329.00 plus resort fees and taxes

Don't wait too long – these rates are available on a first-come, first-served basis!

REQUEST FOR SPEAKERS: 2024 CSHA ANNUAL MEETING AND SPRING SEMINAR

The California Society for Healthcare Attorneys (CSHA) invites proposals for presentations at the 2024 Annual Meeting and Spring Seminar, to be held May 3-5, 2024, at the Everline Resort & Spa in Olympic Valley. CSHA seeks to provide a balanced program for its members -- healthcare attorneys who represent physicians, medical groups, payers, hospitals, and other healthcare facilities. While we are looking for presentations that cover a wide range of topics, based on feedback from our membership, we are especially interested in the following topics: HCAI and OHCA, efficient and effective use of arbitration, legal issues surrounding physician burnout, and employment law topics including the joint employer doctrine.

We are looking for speakers of the highest quality who represent the diversity of the CSHA membership. This is a fantastic opportunity for you to showcase your expertise and contribute to the success of our event. We particularly encourage participation from CSHA members who have not previously presented at our seminars.

Individuals interested in presenting must complete the online application by January 8. Each submission will undergo review by the CSHA Education Committee. After review, speakers will be contacted if they were chosen to be part of the 2024 Annual Meeting and Spring Seminar programming. Speakers selected to present will receive complimentary registration, one night's stay at the host hotel, and transportation reimbursement within California.

For any queries or clarification, please do not hesitate to contact the Education Committee Co-Chairs, Carri Maas, at Carri.maas@kp.org or John Barnes at johnbarnes@dwt.com.

MEMBERSHIP RENEWAL CAMPAIGN

The California Society for Healthcare Attorneys is looking forward to another great year full of information, events, and activities for our members. Your CSHA membership renewal information has been emailed to you – don't let your membership lapse! All members who renew their memberships by the Jan. 14 deadline will automatically be entered into a drawing for a $100 Amazon gift card, so be sure to log in to your CSHA account to renew ASAP!

DIVERSITY TASK FORCE MENTORING PROGRAM

Please join us for the Diversity Task Force's upcoming virtual mentoring program, Advancing Careers through Diversity! Healthcare attorneys with diverse backgrounds often face unique challenges as they strive to reach their professional goals. This is a unique opportunity to network with your peers across the State as well as build lasting mentoring relationships with senior attorneys who can help you advance your career. If you are a junior or mid-level attorney, or a more senior attorney but relatively new to healthcare, please sign up! All CSHA members are welcome to participate! The program will involve a mix of small and large group breakout room interactions designed to encourage interaction and foster connection in a supportive environment. Don't miss this opportunity to build your network and advance your career through diversity!

When: February 7, 2024 from 11am to 1pm.

Where: Via Zoom, link to follow after registration.

Registration: Please visit www.csha.info/ and look under "Upcoming Events" for registration details.

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FROM SUNSET TO SUNRISE: UNRAVELING THE REFORMS IN THE MEDICAL BOARD SUNSET BILL, SB 815 (2023)

by **Shari Covington**
Legal Counsel, California Medical Association

Shari Covington is legal counsel for the California Medical Association (CMA). Her portfolio focuses on medical staff, peer review, the Medical Board, CMA's amicus involvement in litigation affecting California physicians and the practice of medicine, and authoring content for CMA's California Physician's Legal Handbook *(CPLH). She also serves on the board of the Sacramento County Bar Association. Ms. Covington is a graduate of the University at Albany State University of New York with a Bachelor of Arts in English and received her J.D. from Franklin Pierce Law Center in New Hampshire.*

I. Introduction

The Medical Board of California (the Board) has existed since 1876. But its statutory authority to oversee physician licensing and conduct is subject to periodic review by the California State Legislature—a process undertaken for all licensing boards under the auspices of the Department of Consumer Affairs. The Legislature must renew a board's authority before the board's existing statutory authority sunsets. In conducting its joint sunset review oversight of the Board, the Legislature assesses the effectiveness of the Board in protecting the public and regulating the practice of medicine. The process seeks to ensure accountability, transparency, and quality assurance in California health care services. Sunset review of the Board generally occurs every four years, allowing for comprehensive evaluations and reforms to address any legislative concerns.

California recently concluded its Board sunset review process with the enactment of Senate Bill 815[1], which renewed the Board's statutory authority to oversee physician licensing and discipline for another four years, until January 1, 2028. The next sunset review will occur in 2027.

The enacted legislation made several changes in the areas of licensing, disciplinary proceedings, and what constitutes unprofessional conduct. Most of the law's provisions will become effective on January 1, 2024. This article examines the noteworthy changes that are poised to have a substantial impact on physicians, and their attorneys operating within the health care arena.

The Board put forth a series of requested updates to relevant statutes in its sunset background paper, a precursor to the bill that includes the Board's requested changes. The Board's main priorities were to achieve financial solvency and improve communication with consumers regarding the Board's role and enforcement process. SB 815 granted many of the Board's requests.

II. Licensing

Some of the requests of the Board that were granted led to significant changes in physician licensing.

a. Felony Convictions (Bus. & Prof. Code § 2232.5)

Effective January 1, 2024, under section 2232.5 of the Business and Professions Code as amended, a physician's license will be automatically suspended if they are convicted of specified crimes or violations, regardless of whether the violation occurred during their practice as a physician or in any other context. The subset of statutes that fall under this provision includes the following offenses:

1. Sexual abuse, exploitation, misconduct, or relations with a patient
2. Rape, lewd, lascivious, or sexual violence
3. Serious felonies as defined in Section 1192.7 of the Penal Code
4. Selling, transporting, furnishing, administering, giving, possessing with intent to sell, or offering to

> sell, furnish, administer, or give to any person, any fentanyl or fentanyl-laced product without a lawful prescription.

SB 815 originally proposed automatic license revocation for any felony conviction involving moral turpitude, dishonesty or corruption, fraud, or sexual assault, regardless of whether it occurred during the physician's practice or in any other context. Those provisions were ultimately narrowed in response to due process concerns.

b. Modification of License Probation (Bus. & Prof. Code § 2307)

The Board requested and received an extension in the required waiting period before a petition for modification or termination of probation or reinstatement of a license can be considered (Business and Professions Code Section 2307).

Existing law establishes minimum required waiting periods before a petitioner may request reinstatement or a modification. Under current law, licenses surrendered or revoked for unprofessional conduct are subject to a three-year waiting period (two years if good cause is shown) before a petition for reinstatement can be filed (para. (b)(1)). SB 815 lengthens this waiting period to five years (or three years for good cause). For early terminations of probation, current law imposes a two-year waiting period for probations of three years or more (para. (b)(2)). SB 815 revises this waiting period to be the *greater* of two years or more than one-half of the probation term. Notably, the bill also deletes the reference to probations of "three years or more," making paragraph (b)(2) ostensibly applicable to probations of any length of time.

This change, however, creates a potential textual ambiguity and conflict with paragraph (b)(3), which was not amended by SB 815. Paragraph (b)(3) provides that probations of less than three years (as well as conditions or reinstatements of a license surrendered or revoked for mental or physical illness) are subject to a waiting period of one year. If a licensee is placed on probation for two years, paragraph (b)(2) would suggest the licensee must complete the entire term of probation and may not petition for early termination. But paragraph (b)(3) expressly provides a one-year waiting period for probations of less than three years. Drawing on principles of statutory construction, and reading the statute as a whole, it is reasonable to assume that paragraph (b)(3), as the more specific provision relating to shorter probation terms, prevails over paragraph (b)(2), which is more general. A contrary interpretation of paragraph (b)(2) would render paragraph (b)(3) meaningless superfluous. The Board's implementation of these amendments will need to be monitored in the coming months.

SB 815 also amends the law to require the Board to automatically reject a petition for early termination or modification if the Board files a petition to revoke probation while the petition for early termination or modification of the probation is pending.

For example, if a physician is placed on probation for a period of four years due to a disciplinary action, under the new statute the physician would be eligible to apply for early termination of probation after completing *more than* two years of their probationary period ("more than one-half of the probation term," § 2307(b)(2)). However, if the Board initiates a petition to revoke their probation while their early termination request is being reviewed, the request for early termination would be automatically rejected, and the physician would need to continue serving the remaining probationary period.

Similarly, section 2307 as amended extends the Board's authority to deny without a hearing any subsequent petitions filed on a decision to deny the petition for early termination or modification by one year. Current law allows the board to deny without hearing petitions on such cases for two years. Under section 2307 as amended, the board will have three years to deny hearing these petitions.

The Board offered no rationale for these changes but noted that between 2013 and 2022, the Board granted approximately 37% of petitions requesting reinstatement of a physician's license and in the fiscal year 2018-20, granted approximately 58% of the petitions for termination of probation and none of the petitions for modification for probation. The changes in SB 815 will reduce the number of petitions eligible for consideration in any given year.

c. Postgraduate Training (Bus. & Prof. Code §§ 2064.5, 2065, 2096, & 2097)

SB 815 made several notable changes pertaining to postgraduate training licenses (PTLs).

First, the law provides that a PTL issued after January 1, 2020, is valid

for 36 months. Currently, the PTL is only valid until 90 days after the PTL holder has received 12 months credit of board-approved postgraduate training for graduates of medical schools in the United States or Canada or 24 months of board-approved postgraduate training for graduates of foreign medical schools, after which point the PTL holder must get a full physician's and surgeon's license. The current timelines, which have evolved since the creation of the PTL in 2020 to ensure that residents could bill for Medi-Cal and also moonlight, have contributed to licensing backlogs. SB 815 gives residents the flexibility to transition to a full physician's and surgeon's license anytime between completing the 12 months of board-approved postgraduate training for graduates of medical schools in the United States or Canada or 24 months of board-approved postgraduate training for graduates of foreign medical schools and the expiration of the PTL. It should also reduce licensing backlogs by creating a more staggered application timeline for the transition from PTL to full physician's and surgeon's license.

SB 815 also eliminates the requirement that a resident must complete 24 months of their postgraduate training in the same program. Previously, a resident who did not complete 24 of their required 36 months of Board-approved postgraduate training in one program would not be able to renew their license at the time of initial renewal. This change allows physicians who may need to move residency programs more than once the ability to practice in California following residency.

The bill[2] also codifies and clarifies guest rotation licensing requirements. Guest rotations of up to 90 days in an approved post graduate training program in California are currently exempt from licensure pursuant to section 1320 of title 16 of the California Code of Regulations. The statutory requirements outlined in Business and Professions Code section 2065 ensure that guest rotations are clearly articulated in the law and also clarify that the rotation may occur at a participating site affiliated with a program accredited by the Accreditation Council for Graduate Medical Education (ACGME).

The changes to the PTL in SB 815 build upon changes to the PTL process that were made in a budget trailer bill, SB 143, which contained an urgency clause and thus went into effect immediately upon the Governor's signature on September 13, 2023. SB 143 in part modified the statute to extend the timeframe for residents to secure a PTL in California. The new limit is 180 days, an increase from the previous 90 days. This extension applies to residents who have completed one year of Board-approved postgraduate training out of state and are currently enrolled in a California ACGME-accredited residency program. The bill also extended the validity of PTLs that expired between June 1, 2023 and December 31, 2023, to March 31, 2024. This helped avoid pulling residents off rotations due to PTL expirations caused by application processing backlogs at the Board. It should be noted that PTLs now expiring on March 31, 2024 may technically still not expire on that date if the changes in SB 815 extending the validity of all PTLs to 36 months would go beyond that date. For example, pre-SB 143, if a PTL was issued July 1, 2022, it would have expired on September 30, 2023. SB 143 extends the PTL to March 31, 2024. On January 1, 2024, SB 815 will further extend its validity to June 30, 2025.

d. Mexico Pilot Program: Extension of the Non-Renewable License Period. (Bus. & Prof. Code § 853(j))

Another notable change is the Board's ability to extend the three-year nonrenewable license period, under specified circumstances, for physicians in the Mexico Pilot Program[3]. Under this provision, the Board may extend the three-year nonrenewable license period if, prior to January 30, 2024, the licensee was unable to practice more than 30 consecutive business days.

In 2015, there were only 62 Spanish-speaking physicians per 100,000 Spanish speakers.[4] The Mexico Pilot program is intended to increase the number of Spanish-speaking physicians in the community to serve California's large Spanish-speaking population. The program revisions enacted by the SB 815 aim to guarantee that physicians enrolled in the Mexico Pilot Program can take full advantage the three-year nonrenewable license available under the program, even if they have experienced a period of more than 30 days without practicing medicine due to circumstances largely beyond their control (such as visa applications, pregnancy, or credentialing).

III. Unprofessional Conduct

SB 815 makes numerous changes that impact the definition and consequences of unprofessional conduct.

a. Physician Participation in Investigatory Interviews (Bus. & Prof. Code § 2234(g))

Licensees will be subject to a 30-day deadline to participate in investigatory interviews in the absence of good cause. This new timeline underscores the significance of prompt and active involvement in the investigative process, highlighting the expectation for licensees to cooperate fully and expediently. Failure to meet this requirement may result in serious consequences, as it reinforces the notion that non-compliance with investigative procedures constitutes a clear instance of unprofessional conduct.

b. Patient Consent to Release of Medical Records (Bus. & Prof. Code § 2234(h) & (i))

Section 2234(h) of the Business and Professions Code, as amended, makes it an act of unprofessional conduct if a licensee or their representative takes any action intended to coerce patients or their authorized representatives into withdrawing consent for the release of medical records to the Board or the Department of Consumer Affairs' Health Quality Investigation Unit. Additionally, dissuading, intimidating, or tampering with a patient, witness, or any person in an attempt to prevent them from reporting or testifying about a licensee will also constitute unprofessional conduct (subd. (i)). Subdivision (h) may raise potential concerns regarding First Amendment speech considerations, in part due to ambiguities and lack of clarity in its language, including the lack of specific examples of prohibited conduct. Nonetheless, a violation of this rule will be deemed unprofessional conduct by physicians under the statute. It will be of particular interest to observe the practical application and implications of this provision in the future.

c. Maintaining Medical Records (Bus. & Prof. Code § 2266)

In terms of record-keeping, SB 815 imposes a strict mandate that patient records be retained for a minimum of seven years after the last date of service to the patient. The Board sought to align the record retention timeline to the statute of limitations for filing an accusation against a licensee to ensure records are available to support an investigation.[5] This requirement underscores the Board's view of the importance of diligently maintaining comprehensive and easily accessible patient records over an extended period. Failure to retain records for the specified duration constitutes a clear instance of unprofessional conduct.

IV. Administrative Procedure

The below section addresses the various aspects of the different administrative statutes, including the establishment of the Complainant Liaison Unit, changes to the complaint process, electronic submission of fitness for duty questionnaires, and pertinent timelines.

a. Creation of the Complainant Liaison Unit (Bus. & Prof. Code § 2024.5)

The law directs the Board to establish the Complainant Liaison Unit (CLU). The CLU's primary responsibilities include promptly responding to any communications received from the public regarding the complaint review and enforcement process, addressing any inquiries or concerns raised by complainants.

Once a complaint has been referred to a field investigation, the CLU will assist in coordinating communications between the complainant and the investigators involved. In cases where a disciplinary decision has been made, the CLU will respond to any questions from the complainant regarding the appeals process.

To improve the public's understanding of the Board's enforcement process, the CLU will conduct and support public outreach activities to educate the public about the enforcement process and related laws and policies.

Finally, the CLU will evaluate and respond to requests from complainants to review a complaint closure that they believe was made in error.

This section becomes operative six months following the allocation of positions to the Board for implementation in the annual Budget Act. That allocation has not yet occurred.

b. Conduct of Complainant Interviews & Statements (Bus. & Prof. Code §§ 2220.1 & 2220.2)

In terms of the complaint process, the Board will now conduct and

collect complainant interviews from the complainant, patient, or patient representative for cases pertaining to quality of care provided by licenses. Section 2220.1 defines a "patient representative" as the spouse, domestic partner, person responsible for the patient's care, or next of kin. Before closing a complaint, the board must conduct an interview with the complainant, patient, or patient representative if one is identified in the complaint, unless the complaint is anonymous or lacks contact information. If the request for an interview is declined or unanswered within 30 days, the board may close the complaint. However, if additional information is provided after the closure, the board may reopen the matter. As with section 2024.5 (Complainant Liaison Unit), implementation of section 2220.1 is contingent on the allocation of budget and additional staff positions to the board.

Section 2220.2 provides the complainant, patient, or patient representative 60 days from receiving notice to provide a statement relative to the harm they experienced. Notice is provided at the time that the complaint is referred for a field investigation. Any statement provided shall be considered by the Board when adjudicating the case. The section explicitly excludes the Osteopathic Medical Board of California from these requirements.

The utilization of complainant interviews by the Board in investigatory and disciplinary proceedings remains uncertain. The Board's use of these complainant statements is likely to be a topic of legal interest and will be closely monitored by the legal community.

c. Electronic Fitness for Duty Questionnaires (Bus. & Prof. Code § 2425)

Effective January 1, 2024, the law will allow for the electronic provision and completion of fitness for duty questionnaires at license renewal, which determine a physician's ability to practice medicine safely. The language of the statute has been revised to replace the specific mention of afflictions such as mental, physical, emotional, or behavioral conditions with the broader term "disorder" that may affect a licensee's ability to practice medicine safely.

V. Discovery

These provisions address various aspects of the law, including the exchange of expert testimony information, compliance of pharmacies with record requests, tolling of the statute of limitations (SOL) in certain circumstances, and the establishment of record production timelines.

a. Record Release Tolling Revisions (Bus. & Prof. Code § 2225.5)

SB 815 made changes to SOL tolling for the Board's ability to file accusations against a physician. For licensees, the SOLs will be paused upon the service of an order to show cause. This pause will remain in effect until the subpoenaed records are produced, including any period when the licensee is not in compliance with the court order or during related appeals. The pause will also continue if and until the court decides not to issue an order mandating the release of records to the Board.

In cases where a licensee fails or refuses to comply with a court order that requires the release of records, civil penalties will be imposed. The penalty is set at one thousand dollars ($1,000) per day for each day that the documents are not produced after the court order's deadline, up to a maximum of ten thousand dollars ($10,000). However, if it is determined that the court order itself is unlawful or invalid, the penalties will not apply.

Similarly, for healthcare facilities, beginning next year, the SOL for filing accusations will be tolled during any period the healthcare facility is not in compliance with the court order, during related appeals, or if and until the court declines to issue an order mandating the release of records to the board.

b. Exchange of Expert Testimony Information (Bus. & Prof. Code § 2334)

SB 815 requires an earlier exchange of expert testimony information. This exchange must be completed within 90 calendar days prior to the originally scheduled commencement date of the hearing, as opposed to 30 days. This means that any expert witness statement will also need to be submitted in accordance with these new timeframes.

c. Modification to Pharmacy's Record Production Requirements (Bus. & Prof. Code § 2225.7)

SB 815 established new requirements for timely provision of pharmacy records to the Board. Upon request from a law enforcement officer or a representative authorized by the Board, the owner, corporate officer, or manager of an entity

licensed by the Board of Pharmacy is obligated to provide requested records to the Board or its authorized representative within three business days of the request. However, the entity has the option to request, in writing, an extension of up to 14 calendar days from the date the records were initially requested. Board approval is required for the extension request. If the Board does not deny the extension request within two business days of receipt, the extension shall be considered approved.

VI. Licensing Fees Increase (Bus. & Prof. Code §§ 2435, 2307.5, 2952)

Effective January 1, 2024, there will be an increase in the initial physician's and surgeon's license fee. The fee will rise from $863 to $1,151. On January 1, 2027, the initial fee will rise again to $1,255; additionally, biennial license renewals for licenses that expire after January 1, 2027 will be subject to this same fee. This is a marked improvement from the $1,350 licensing fee that the Board originally sought for all licenses.

In addition, the Board may now collect reasonable costs for its expenses related to any person seeking a license reinstatement or modification of a penalty which caused their license to be revoked, suspended, or placed on probation. Reasonable costs are not defined in the statute.

VII. Conclusion

SB 815 introduces several provisions that have a significant impact on the legal landscape for attorneys practicing in California. These provisions address various aspects of the law, such as the establishment of new units, modifications to complaint processes, timelines for record production, and adjustments to fees and licensing requirements. It is essential for attorneys to become familiar with these changes to effectively advise and represent their clients. By staying informed and adapting to these evolving legal requirements, attorneys can confidently navigate the regulatory landscape and provide the highest quality of legal counsel to their clients.

END NOTES

1 S.B. 815 (Stats. 2023, Ch. 294).

2 This change was added to SB 815 through a process called double-jointing, which ensures that bills that amend the same code section do not cancel each other out if they are both signed. See California State Senate, Glossary of Terms, "Double Joint," https://www.senate.ca.gov/glossary. The changes to the guest rotation language were originally proposed in Assembly Bill 1646 (Nguyen) (Stats. 2023, ch. 257). Because both bills amended section 2065 of the Business and Professions Code, these changes were incorporated into SB 815 to avoid either bill overriding the other. Stats. 2023, ch. 294, § 32.

3 Cal. Bus. & Prof. Code § 853(j).

4 Paul Hsu, et al., UCLA Latino Politics and Policy Initiative, *California's Language Concordance Mismatch: Clear Evidence for Increasing Physician Diversity 2* (2018), https://latino.ucla.edu/wp-content/uploads/2021/08/AltaMed-Policy-Brief-1.pdf.

5 Medical Board of California, Sunset Review Oversight Report 2022 at 184 (2022), https://mbc.ca.gov/Download/Reports/sunset-report-2022.pdf.

CALIFORNIA MAKES HISTORY (AGAIN) PASSING FIRST STATE-WIDE HEALTHCARE WORKER MINIMUM WAGE STANDARD

by **Bailey Bifoss**
Seyfarth Shaw's Labor & Employment Department

Bailey Bifoss is an associate at Seyfarth Shaw's Labor & Employment Department, based in San Francisco. She focuses on practical solutions to avoid litigation and increase employment compliance, as well as developing effective litigation strategies to combat single-plaintiff and class action claims. Bailey has litigated and resolved numerous matters before federal and state courts and administrative agencies.

by **Parnian Vafaeenia**
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On October 13, 2023, California made history when Governor Gavin Newsom signed SB 525, the first state-wide Healthcare Worker Minimum Wage Standard, which will raise minimum wages for healthcare workers across the state effective June 1, 2024. The bill includes five separate minimum wage schedules for covered healthcare employees depending on the nature, size, and structure of the employer's business.

THE ORIGIN AND DEVELOPMENT OF SB 525

For those monitoring the situation closely earlier this year, the passage of SB 525 may come as something of a surprise.

In Senate analyses of early versions of SB 525, lawmakers admitted that union organizing efforts originally motivated the state-wide analysis of pay for healthcare workers. Indeed, in 2022, the SEIU-United Healthcare Workers West ("SEIU-UHW") spearheaded several local initiatives that had been pending in Los Angeles County, San Diego County, and other California cities. Those initiatives would have capped the compensation that could have been paid to any employee of a covered healthcare company and were widely criticized as restricting hospitals and healthcare systems' ability to compensate their executives.

Enter SB 525, early versions of which were similarly unpopular. Many agreed with the SEIU-UHW that healthcare wages should increase, but opponents argued that the bill asked healthcare companies for too much too fast, and without regard for how hospitals and other systems would foot the bill. For example, the California Hospital Association published a report in July citing the "grave risks to access to care that passage of this bill would entail," and explaining there was "no question this law would reduce access to medical services, increase health care costs, and diminish health care employment opportunities."

Relief came through several subsequent drafts of the legislation, and the final version of the law has a phase-in approach, an opportunity for healthcare companies to apply for waivers, and certain limited exclusions from the new pay requirements. Healthcare providers and the hospital lobby further got behind the law based on concessions from labor—the unions agreed to a 10-year moratorium on sponsoring local ballot measures to force pay raises at hospitals and other medical facilities, as well as a four-year break in pushing for legislation or ballot measures targeting dialysis centers.

Regardless of the horse trades ultimately required to have reached a successful resolution, a deal has now been struck. Thus, healthcare employers will do well to consider what SB 525 means for them in the years to come.

THE BROAD COVERAGE OF SB 525

The coverage of SB 525 is extensive both in terms of the facilities and workers covered. However, there are exclusions and limitations. Only "Covered Health Care Employers" owe increased minimum wages to their "Covered Health Care Employees." Additionally, even once a facility has confirmed that it and

its employees are covered by the law, the facility must further evaluate *which* wage scale it is subject to. To comply with the law, employers need to confirm they know where they stand within its scope.

Employers Covered

SB 525's provisions apply to "Covered Health Care Employers, as that term is defined under the soon-to-be added Labor Code sections 1182.14 and 1182.15. This will include:

1. Hospitals: licensed general acute care hospitals, licensed acute psychiatric hospitals, and other special hospitals.
2. Clinics: specialty care clinics, dialysis clinics, community clinics, psychology clinics, government run clinics, rural health clinics, and urgent care clinics.
3. Psychiatric and Mental Health Facilities: mental health rehabilitation centers, county mental health facilities, and psychiatric health facilities.
4. Licensed Skilled Nursing Facilities: including those that are owned, operated, or controlled by a hospital or integrated health care delivery system or health care system.
5. Home Health Care: including licensed home health agencies and a patient's home when health care services are delivered by an entity owned or operated by a general acute care hospital or acute psychiatric hospital.
6. Licensed Residential Care Facilities for the Elderly.
7. Integrated Health Care Delivery System Work Sites.
8. Ambulatory Surgical Centers Certified for Medicare Participation.
9. Physician Groups.
10. County Correctional Facilities Providing Health Care Services

Just as important is understanding who the term "Covered Health Care Employers" excludes. Not covered by the law are: (1) hospitals owned, controlled, or operated by the State Department of State Hospitals; (2) tribal clinics exempt from licensure; and (3) outpatient settings conducted, maintained, or operated by a federally recognized Indian tribe, tribal organization, or urban Indian organization.

Additionally, even if a company is a "Covered Health Care Employer," it may seek a waiver from coverage if it believes it cannot comply with the new law's requirements. With that being said, companies should be prepared to lift the hood to justify their request for a waiver. To qualify, a company must provide documentation of its financial condition as well as that of any parent or affiliated entity.

Employees Covered

Importantly, SB 525 is not limited to employees who provide traditional medical care. The term "Covered Health Care Employee" is defined broadly to include employees who provide patient care, health care services, or services supporting the provision of health care. Examples span from nurses and physicians to clerical workers, gift shop workers, janitors, schedulers, and billing personnel.

Contracted and subcontracted employees are also included if they:

1. Perform contracted or subcontracted work primarily on the premises of a health care facility to provide health care services or services supporting the provision of health care;
2. Are employed by an employer that contracts with the health care facility employer, or with a contractor or subcontractor to the health care facility employer, to provide health care services, or services supporting the provision of health care; or
3. Perform work for a health care facility employer that directly or indirectly, or through an agent or any other person, exercises control over the employee's wages, hours or working conditions.

Covered Health Care Employees will be able to enforce their rights under this new law through civil action, in the same manner they can currently enforce other minimum wage requirements.

The Scope of Minimum Wage Obligations

SB 525 includes five separate minimum wage schedules, but the minimum wage rates set forth under two of these schedules are identical. Thus, Covered Health Care Employers will fall within one of the four following groups:

1. **Group 1:** Covered health care facilities with 10,000 or more full-time equivalent employees, covered health care facility employers that are part of an

integrated health care delivery system or health care system with 10,000 or more full-time equivalent employees, covered dialysis clinics, and covered health facilities that are owned, affiliated, or operated by a county with a population of more than 5,000,000 as of January 1, 2023.

- June 1, 2024 to May 31, 2025: $23 per hour.
- June 1, 2025 to May 31, 2026: $24 per hour.
- June 1, 2026 to August 1, 2027: $25 per hour.

2. **Group 2:** Covered hospitals with high populations of Medicare/Medicaid patients, covered rural independent health care facilities, and covered health care facilities that are owned, affiliated or operated by a county with a population of less than 250,000 as of January 1, 2023.
   - June 1, 2024 to May 31, 2033: $18 per hour with 3.5 percent increases annually.
   - June 1, 2033 to August 1, 2034: $25 per hour.
3. **Group 3:** Covered primary care community or free clinics that are open for limited services of no more than 40 hours a week and that are not conducted or maintained by a government entity, covered community clinics along with any associated intermittent clinics exempt from licensure, covered rural health clinics, and covered urgent care clinics that are owned by or affiliated with a community clinic.
   - June 1, 2024 to May 31, 2026: $21 per hour.
   - June 1, 2026 to May 31, 2027: $22 per hour.
   - June 1, 2027 to August 1, 2028: $25 per hour.
4. **Group 4:** all other covered health care facilities.
   - June 1, 2024 to May 31, 2026: $21 per hour.
   - June 1, 2026 to May 31, 2028: $23 per hour.
   - June 1, 2028 to August 1, 2029: $25 per hour.

Following these minimum wage increases, the Director of Finance will calculate an adjusted minimum wage on or before August 1 of the following year, and on or before each August 1 thereafter – seemingly in perpetuity. The calculation will increase the minimum wage by 3.5% or the rate of change in the averages for the U.S. Consumer Price Index for Urban Wage Earners and Clerical Workers, whichever is lower.

Notably, the minimum wage requirements summarized above will impact a Covered Health Care Employer's *exempt* California employees as well, to the extent those employees qualify as Covered Health Care Employees. These employees will have to earn a monthly salary equivalent to no less than: (1) 150% of the applicable health care worker minimum wage or (2) 200% of the State's generally-applicable minimum wage—whichever is greater—for full-time employment in order to qualify as exempt under California's laws.

PRACTICAL IMPACTS AND KEY TAKEAWAYS

Aside from the basic increases to employee minimum wage, employers will want to pay attention to the many potential downstream impacts of the law. For example, many facilities may have collective bargaining agreements that need to be evaluated in light of the new law. Likewise as to any agreements with staffing or travel companies placing temporary employees at a facility. All facilities should be prepared for an increase in the cost of their meal and rest period compliance (since meal and rest period premiums must be paid at employees' regular rate of pay, which will increase with the minimum wage hikes). The same will hold true for employers' compliance with their reporting time and split-shift obligations.

SB 525 does not take effect until June 2024, so employers have some time to ensure they are prepared to comply with its provisions. However, the changes required as a result of the law may be extensive for many facilities, and employers would do well to get started on their evaluation of the law sooner rather than later.

NOT SO FAST! BANKRUPTCY COURT HOLDS THAT FEDERAL LAW STOPS MEDI-CAL SUSPENSION OF PAYMENTS

by **Rebecca Wicks**
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In the pending chapter 11 bankruptcy case of Borrego Community Health Foundation ("Borrego" or the "Debtor"),[1] the United States Bankruptcy Court for the Southern District of California held that a threatened suspension of Medi-Cal payments violates the automatic stay imposed by the Bankruptcy Code[2] and was not an exercise of police and regulatory powers that would exempt it from the automatic stay.[3]

Borrego is a nonprofit Federally Qualified Healthcare Center that operates eighteen clinics, two pharmacies, and six mobile units in underserved areas of San Diego and Riverside Counties with Medi-Cal payments accounting for approximately 44% of Borrego's revenue. Borrego's bankruptcy was precipitated by California Department of Health Care Services ("DHCS") threatening to suspend Medi-Cal payments to the Debtor (the "Suspension"), which effectively compelled third-party payors with contracts with Borrego to terminate those contracts. As it would be unable to operate without Medi-Cal payments, and the subsequent loss of a significant number of patients, Borrego filed its chapter 11 bankruptcy petition on September 12, 2022.

Filing a bankruptcy petition invokes the protection of the automatic stay pursuant to section 362 of the Bankruptcy Code. [4] The automatic stay prohibits (i) "the commencement or continuation … of a[n] … action or proceeding against the debtor[;]"[5] (ii) "any act to obtain possession of property of the estate or of property from the estate or to exercise control over property of the estate[;]"[6] and (iii) "any act to collect, assess, or recover a claim against the debtor[.]"[7]

Despite knowledge of the bankruptcy, DHCS announced its intention to proceed with the Suspension. Consequently, Borrego filed (i) a Complaint for Declaratory Judgment and Preliminary and Permanent Injunctive Relief, or in the Alternative, for Writ of Mandate Under Code of Civil Procedure 1085 and (ii) an Emergency Motion: (I) to Enforce the Automatic Stay Pursuant to 11 U.S.C. § 362; or (II) Alternatively For Temporary Restraining Order (the "Emergency Motion"). Borrego argued that DHCS' threatened Suspension violated the automatic stay.

Conversely, DHCS asserted that its actions were not stayed due to the police power exception under 11 U.S.C. § 362(b)(4). The police power exception provides that the automatic stay does not bar "the commencement or continuation of an action or proceeding by a governmental unit … to enforce [its] police or regulatory power." [8] A police or regulatory power requires "the enforcement of laws affecting health, welfare, morals and safety, but not regulatory laws that directly conflict with the control of the res or property of the bankruptcy court."[9]

At the outset, the Court noted that the suspended payments—as accounts receivables—were estate property and therefore protected by the automatic stay, unless an exception applies.[10] The Court used two tests to determine whether the police power exception applies: (i) the pecuniary interest test, and (ii) the public policy test.[11]

First, the Court determined that

DHCS failed the pecuniary interest test. The pecuniary interest test provides that the automatic stay will apply if the action is meant to protect the government's pecuniary interest, rather than public safety and welfare.[12] Following the analysis of other courts,[13] the Court found that the Suspension sought to protect DHCS's interest in the Medi-Cal funds, particularly where DHCS threatened to suspend millions of dollars in potential payments for properly performed post-petition work by Borrego. Emphasizing the fact that the Suspension did not require the Debtor to stop providing services, the Court found that the Suspension was not related to matters of public safety and health and would allow DHCS to obtain an unfair advantage over the Debtor's other creditors.

Second, the Court determined that DHCS failed the public policy test. The public policy test distinguishes between government actions meant to effectuate public policy in contrast to government actions that adjudicate private rights.[14] Here, the Court determined that the motivation behind Suspension was due to DHCS's allegations of the Debtor's breach of a prepetition settlement agreement. Importantly, the Court found that pursuing DHCS's breach of contract claim was an adjudication of private rights and did not serve a public purpose.[15]

Ultimately, the Court granted the Emergency Motion, in part, and enforced the automatic stay, noting that DHCS's regulatory power does not extend to fiscal control of the Debtor.[16] Thus, Borrego was able to continue to treat patients while negotiating an overall resolution with DHCS. Faced with the Court's ruling that it could not impose the Suspension, DHCS agreed to participate in mediation with Borrego. This mediation resulted in a global settlement being approved by the Bankruptcy Court in March 2023. [17]

END NOTES

1 *In re Borrego Cmty. Health Found.*, Case No. 22-02384-LT11 (Bankr. S.D. Cal.). All the documents filed in the chapter 11 bankruptcy case and the pending adversary proceeding, entitled *Borrego Cmty. Health Found. v. Cal. Dep't of Health Care Servs.*, Adv. Pro. No. 22-90056-LT (Bankr. S.D. Cal.), are available free of charge at http://www.kccllc.net/borregohealth.

2 11 U.S.C. §§ 101-1531.

3 *See* Tentative Ruling [Dkt. No. 48] (adopted by Dkt. No. 55), *Borrego Cmty. Health Found. v. Cal. Dep't of Health Care Servs.*, No. 22-90056-LT (Oct. 6, 2022).

4 11 U.S.C. § 362.

5 11 U.S.C. § 362(a)(1).

6 11 U.S.C. § 362(a)(3).

7 11 U.S.C. § 362(a)(6).

8 11 U.S.C. § 362(b)(4).

9 *In re Universal Life Church, Inc.*, 128 F.3d 1294, 1297 (9th Cir. 1997) (citing *Hillis Motors, Inc. v. Hawaii Auto. Dealers' Ass'n*, 997 F.2d 581, 591 (9th Cir.1993).

10 Borrego relied on *In re THG Holdings*, LLC, 604 B.R. 154, 160-61 (Bankr. D. Del. 2019) in asserting this position, which the Court adopted. *See Borrego*, No. 22-90056-LT [Dkt. No. 3 at 27-29] (Sept. 27, 2022).

11 *Borrego*, No. 22-90056-LT [Dkt. No. 48 at 6] (citing *Lockyer v. Mirant Corp.*, 398 F.3d 1098, 1108 (9th Cir. 2005); *Universal Life Church, Inc.*, 128 F.3d at 1297).

12 *Id.* (citing *NLRB v. Cont'l Hagen Corp.*, 932 F.2d 828, 833 (9th Cir. 1991)).

13 *Id.* at 7 (citing *In re Medicar Ambulance Co., Inc.*, 166 B.R. 918, 927 (Bankr. N.D. Cal. 1994) (finding that suspension of Medicare payments "directly and impermissibly conflicts with the court's control of property of the estate" and was "the equivalent of the seizure of property or the enforcement of a judgment.") and *THG Holdings*, 604 B.R. at 161 (holding that withholding Medicare payments for prepetition wrongs was "the exact conduct that the pecuniary interest test was designed to prohibit.")).

14 *Id.* (citing *Lockyer*, 398 F.3d at 1109).

15 *Id.* at 4 (citing *In re Corporacion de Servicios Medicos Hospitalarios de Fajardo*, 805 F.2d 440, 445-46 (1st Cir. 1986) (holding that section 362(b)(4) of the Bankruptcy Code does not permit government agencies "to enforce contractual rights, even if related to the agency's general regulatory power.")).

16 *See* Findings of Fact and Conclusions of Law Re: Emergency Motion to (I) Enforce the Automatic Stay or (II) Alternatively for Temporary Restraining Order [Dkt. No. 65], *Borrego*, No. 22-90056-LT (Oct. 26, 2022).

17 *See* Order on Debtor's Motion to Approve Compromise Among Debtor, Official Committee of Unsecured Creditors, and California Department of Heath Care Services [Dkt. No. 544], *In re Borrego Cmty. Health Found.*, No. 22-02384-LT11 (March 7, 2023).

APPELLATE CASE SUMMARIES

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CMA's standing to sue health insurer under the UCL based on diverting resources to oppose a business practice presents a triable issue

California Medical Association v. Aetna Health of California Inc. (July 17, 2023) __ Cal.5th __ [2023 WL 4553703]

Insurer Aetna Health of California implemented a policy that threatened to terminate in-network providers' contracts for referring patients to out-of-network providers. The California Medical Association (CMA) sued Aetna, alleging it violated the unfair competition law (UCL) (Bus. & Prof. Code, § 17200 et seq.) by unlawfully interfering with the medical judgment of physicians. The UCL permits a claim by a private plaintiff who "suffered injury in fact and has lost money or property" that was "a result of the unfair competition." (Bus. & Prof. Code, § 17204.) Aetna moved for summary judgment, arguing that CMA lacked UCL standing because it had not lost money or property as a result of Aetna's policy, and the policy applied to physicians, not to CMA. CMA opposed summary judgment, arguing that it diverted resources (primarily staff time) in response to the policy. The trial court granted Aetna's summary judgment motion on standing grounds, ruling that CMA's diversion of resources was not a sufficient "injury in fact." The Court of Appeal affirmed, and the Supreme Court granted review.

The Supreme Court reversed, holding that CMA raised triable issues as to the UCL standing requirements. The Court explained that an organization's diversion of paid staff time and other resources may result in lost "money or property" and thus satisfy the UCL's "injury in fact" requirement. The Court concluded that CMA used staff time to respond to Aetna's policy when it could have used that time for other projects. The Court also held that an organization claiming injury for diverting resources must show that the defendant's actions threatened the organization's preexisting mission, causing it to use resources to address the threat before preparing for litigation. Here, there was a triable issue whether CMA diverted resources in response to a perceived interference with physicians' medical independence and thus public health (both objects of CMA's mission). The Court reasoned that allowing CMA to sue based on its diversion of resources did not subvert the injury requirement or risk abuse of the UCL because CMA is a bona fide organization with an interest in public health, not an organization created for the purpose of litigation.

State-law tort and statutory claims against health insurer are expressly preempted by Medicare Part C

Quishenberry v. UnitedHealthcare, Inc. (July 13, 2023) __ Cal.5th __ [2023 WL 4511572]

Larry Quishenberry's father was insured under Medicare Part C, a federal program that subsidizes the cost of private healthcare plans for beneficiaries. Quishenberry's father was hospitalized for a broken hip, then transferred to a skilled nursing facility where he developed severe pressure sores that were not properly treated. He died after discharge. Quishenberry sued his father's health insurer and the healthcare services

administrator who managed his father's Medicare Advantage (MA) benefits, alleging state common law claims of negligence and wrongful death, and a claim under California's Elder Abuse Act. Quishenberry claimed the insurer and administrator breached their duty to ensure his father received the skilled nursing benefits to which he was entitled under his healthcare plan as outlined by Medicare Part C and federal regulations. The trial court sustained defendants' demurrers, ruling that Quishenberry's state-law claims were preempted by Medicare Part C's preemption provision. The Court of Appeal affirmed. Quishenberry obtained review in the California Supreme Court.

The Supreme Court affirmed. It explained that preemption may be either express or implied, to the extent federal and state laws conflict in addressing the same rights or restrictions. Medicare Part C's express preemption provision states that the "standards established under" Part C "shall supersede any State law or regulation" concerning MA plans. (42 U.S.C. § 1395w26(b)(3).) Accordingly, state-law standards that duplicate federal standards are preempted because the express preemption provision covers "any" duty affecting MA plans, regardless of whether they are based on federal standards. Such language contrasts with other federal laws that explicitly preempt state-law standards that "differ" from federal standards. Overruling prior appellate decisions, the Court held that the phrase "*any* State law or regulation" covers both statutory *and common law duties*, so that claims based on duties found in the Elder Abuse Act are preempted. It explained that the phrase "with respect to MA plans" covers both statutory and regulatory provisions referencing MA plans *as well as* generally applicable state law duties allowing regulation of MA plans. Finally, the Court held that section 1395w26(b)(3) preempted all of Quishenberry's claims because a trier of fact considering those claims would have to decide whether the insurer and plan administrator denied treatment that his father was entitled to receive under Medicare Part C and relevant federal regulations.

Federally qualified health center's educational outreach expenses are reimbursable under Medi-Cal

Family Health Centers of San Diego v. State Dept. of Health Care Services (July 24, 2023, S270326) __ Cal.5th __ [2023 WL 4697232].

Federally qualified health centers (FQHCs) receive federal funding to provide basic health care to underserved communities regardless of patients' ability to pay. Federal law requires FQHCs to educate underserved communities about obtaining needed healthcare. States must fully reimburse FQHCs for the costs of providing medical assistance to Medicaid beneficiaries that are "reasonable and related to the cost of furnishing such services." Family Health Centers of San Diego, which operates several FQHCs, sought reimbursement from the state Medicaid program, Medi-Cal, for outreach expenses, such as sending workers into the community to provide information about available healthcare services. An auditor at the State Department of Health Care Services (DHCS), which administers Medi-Cal, determined that these outreach expenses were nonreimbursable advertising expenses. Family Health administratively appealed, but an administrative law judge (ALJ), relying on the federal Centers for Medicare & Medicaid Services' Provider Reimbursement Manual (Manual), ruled the outreach expenses were nonreimbursable because they did not involve patient care and were advertising aimed at patient recruitment.

Family Health filed a petition for writ of administrative mandamus, which the superior court denied. Family Health appealed. The Court of Appeal affirmed, holding that the ALJ did not abuse its discretion by finding that Family Health's outreach expense had the purpose of recruiting new patients and increasing utilization of the FQHC, making it a nonreimbursable advertising expense under the Manual. The Supreme Court later granted Family Health's petition for review.

The Supreme Court reversed and remanded for further proceedings. The court found nothing in the Manual or regulatory scheme established that outreach costs are nonreimbursable merely because they have the incidental effect of recruiting new patients and increasing utilization of FQHCs. To determine whether an outreach expense is "reasonably related, directly or indirectly, to patient care" requires distinguishing between costs associated with *educating* the public and public relations activities

designed to present a positive public image regarding patient care (which are reimbursable) and *advertising* costs designed to generate revenue by convincing patients to seek care at a particular facility, rather than its competitors (which are nonreimbursable). Here, the ALJ failed to apply that standard, so the court reversed and remanded to allow the DHCS to reconsider the reimbursability of Family Health's outreach expenses under the correct standard.

Personal representative could not compel production of a minor's medical records without proving they were withheld in bad faith

Vilches v. Leao (July 28, 2023, A163638) __ Cal.App.5th __ [2023 WL 4839283]

Frank Vilches, the guardian of his minor daughter, hired therapist Michelle Leao to treat his daughter. Vilches later requested copies of his daughter's therapy records. Leao denied the request based on her determination that releasing the records would adversely affect the daughter's well-being and the patient-counselor relationship. Vilches sued, alleging that Leao violated Health and Safety Code section 123110, which grants a minor's personal representative access to patient records. Vilches sought injunctive relief directing Leao to release the requested records and an award of attorney fees, but did not seek damages. Leao moved for summary judgment on the ground that she made the statutory determination required to prevent disclosure of the records under section 123115, subdivision (a)(2), an exception to the right of access in section 123110. The trial court granted Leao's motion, and Vilches appealed.

The Court of Appeal affirmed. The court explained that the right of access to patient records in section 123110 is subject to the exception in section 123115, subdivision (a)(2), which allows healthcare providers to deny access if it would detrimentally affect the minor. The court held, as a matter of first impression, that a representative seeking to compel disclosure must establish that the provider acted in bad faith in denying access. Here, Leao presented uncontradicted evidence that her decision to block access was based on her clinical judgment that disclosure would have a detrimental effect on the minor daughter's well-being, particularly if Vilches used the notes to "coach" his daughter for an upcoming custody proceeding. The court rejected Vilches' argument that the section 123115 exception applied only to actions seeking damages, construing it to apply equally to actions seeking injunctive relief. The court also declined to second-guess Leao's clinical judgment: "untrained members of the judiciary should not be second-guessing the clinical judgment of therapists concerning their minor patients' well-being and the patient-counselor relationship."

Hospital's failure to provide pretreatment disclosure of emergency medical evaluation fees beyond what is required by statute is not actionable

Moran v. Prime Healthcare Management, Inc. (Aug. 7, 2023, G060920) __ Cal.App.5th __, 2023 WL 5012110

Gene Moran received emergency care at a Prime Healthcare hospital and was charged an emergency room evaluation and management services (EMS) fee in addition to the charges for treatment provided. The fee was listed in the hospital's published chargemaster, as required by state and federal statutes, but was not further disclosed at the time of treatment. Moran sued Prime, alleging that its failure to disclose the EMS fee violated the Unfair Competition Law (UCL) and the Consumer Legal Remedies Act (CLRA) because the fee was effectively hidden from patients who might otherwise seek cheaper treatments. Prime moved to strike, arguing that there was no duty to disclose the fees beyond the requirements of state and federal regulations. The trial court granted the motion and Moran appealed.

The Court of Appeal affirmed. The court observed that several recent opinions addressed UCL and CLRA claims regarding EMS fees, including *Naranjo v. Doctors Medical Center of Modesto, Inc.* (2023) 90 Cal. App.5th 1193, which the Supreme Court accepted for review on July 26, 2023. Most of these cases held either that hospitals had no duty to disclose beyond state and federal regulatory requirements, or that the plaintiff failed to adequately allege reliance under the CLRA. *Naranjo* was the only decision allowing the plaintiff's claim to proceed on the merits. *Naranjo* held that the hospital's exclusive knowledge of its EMS fee, which was not reasonably accessible to the patient, led to an actionable claim under the CLRA and UCL. But the *Moran* court declined

to follow *Naranjo*, and instead followed the majority rule—disclosing chargemaster rates under applicable statutes and regulations forecloses a duty to make additional pretreatment disclosure of the EMS fee. The court explained that numerous state and federal rulemaking bodies have developed an extensive statutory and regulatory scheme to provide price transparency for medical services while avoiding price disclosure requirements that might dissuade patients from receiving urgently needed treatment due to cost. Accordingly, Moran's claims were not actionable under the UCL. In addition, Moran failed to allege a viable CLRA cause of action because the hospital did not conceal its EMS fee (it was in the published chargemaster), and because Moran failed to adequately plead reliance (given the severity of his medical emergencies, there was no reasonable inference that disclosing the EMS fee would have caused him to seek treatment elsewhere).

Health plan's duty to transport conservatee to psychiatric facility for assessment and evaluation is triggered by an authorized professional's custodial determination, not by the conservator's demand

Rhonda S. v. Kaiser Foundation Health Plan (July 28, 2023, B318650) __ Cal.App.5th __ [2023 WL 5318406], ordered published Aug. 18, 2023

Rhonda S. was appointed as the conservator of her adult son (David, who suffers from schizophrenia) under the Lanterman-Petris-Short Act (LPS; Welf. & Inst. Code, § 5350). Both Rhonda and David are Kaiser HMO health plan enrollees. When David's condition worsened, Rhonda asked his psychiatrist to order David transported to a Kaiser facility for admission and treatment, but the psychiatrist declined to do so. Kaiser declined Rhonda's request as "not medically necessary" because no doctor had evaluated David and validated Rhonda's concerns. Kaiser suggested that Rhonda arrange an evaluation by the Psychiatric Mobile Response Team, but Rhonda did not do so. David continued to decline until he was apprehended by police and placed under a LPS section 5150 involuntary hold. Rhonda sued Kaiser seeking a declaration of its obligations to transport and accept for assessment and evaluation conservatees like David upon the conservator's demand. The trial court sustained Kaiser's demurrer, and Rhonda appealed.

The Court of Appeal affirmed. The court rejected Rhonda's argument that section 5150, subdivision (a), required Kaiser to transport and admit David for an assessment and evaluation. The statutory language is permissive, not mandatory, and provides that authorized persons (peace officers and designated professionals) "may, upon probable cause, take . . . the person into custody . . . for assessment, evaluation, and crisis intervention." Kaiser's statutory obligation to perform a minimum assessment and evaluation was not triggered here because no authorized person exercised professional judgment to recommend taking David into custody. Rhonda lacked authority to trigger these statutory requirements. Finally, the court rejected Rhonda's contention that Kaiser had a per se obligation to pay for David's ambulance transportation, assessment, and evaluation whenever she requested it, explaining that Kaiser's obligation arises only when an "Emergency Medical Condition" exists and such a condition is not presumed to exist merely because David had been adjudicated to have a grave disability.

Medical screening business can be liable (as an employer's agent) for FEHA violations.

Raines v. U.S. Healthworks Medical Group (Aug. 21, 2023, S273630) __ Cal.5th __ [2023 WL 4697232]

Kristina Raines was offered employment contingent upon a medical screening by U.S. Healthworks Medical Group (USHW), an agent of her future employer. After she responded to all but one question on an extensive health history questionnaire, USHW terminated the exam. Raines's employment offer was revoked as a consequence. Raines sued USHW in federal court for violating California's Fair Employment and Housing Act (FEHA), which states it is an "unlawful employment practice" for "any employer" "to make any medical or psychological inquiry of an applicant." (Gov. Code, § 12940.) FEHA defines an employer to include "any person acting as an agent of an employer." (*Id.*, § 12926, subd. (d).) In context, these provisions could be read two ways: (1) that liability for violating the statute resides with the employer, not the agent; or (2) that an employer's agents are liable to the same extent as the employer. The district court concluded that FEHA

did not impose liability on USHW. Raines appealed to the Ninth Circuit, which asked the California Supreme Court to resolve whether, under the FEHA, a business entity acting as an agent of an employer may be directly liable for employment discrimination.

The California Supreme Court answered the Ninth Circuit's question in the affirmative—agents such as USHW may be directly liable for FEHA violations in appropriate circumstances. The Court construed section 12926 to mean that an agent of an employer counts as an "employer" under FEHA. The Court found further support for its interpretation in FEHA's legislative history, which showed that the Legislature borrowed from National Labor Relations Act provisions interpreted to impose employer status on certain employer agents. Consulting analogous federal decisions regarding antidiscrimination laws, the Court determined that a business-entity agent could bear direct FEHA liability only when it carried out FEHA-regulated activities on behalf of an employer. The Court further reasoned that public policy supported its construction: extending FEHA liability to the business entity most directly responsible for the violation furthers FEHA's remedial purpose. Finally, the Court distinguished its earlier opinions holding that *individual* employees of the same employers are *not* subject to FEHA liability. The rationale for those opinions did not apply to a business entity employing five or more employees that carries out FEHA-regulated activities on behalf of an employer.

Insurer's delivery to the patient of a check payable jointly to the patient and a hospital in the amount of the hospital's lien fails to satisfy the lien.

Long Beach Memorial Medical Center v. Allstate Ins. Co. (Sept. 19, 2023, B321876) __ Cal.App.5th __ [2023 WL 6115891]

Long Beach Memorial Medical Center (Medical Center) treated Vernon Barnes for injuries he suffered in a car accident. Barnes submitted a personal injury claim to Allstate, which insured the driver who Barnes claimed was at fault for the accident. The Medical Center notified Allstate that it was asserting a $116,714.67 lien against Barnes' recovery under the Hospital Lien Act (HLA). Barnes and Allstate settled the claim for $300,000. Allstate sent Barnes a check payable jointly to Barnes and the Medical Center for the entire lien amount, in addition to another check payable to Barnes and his attorney. The check payable to Barnes and the Medical Center for $116,714.67 was never deposited and eventually expired. The Medical Center sued Allstate, alleging that it violated the HLA (Civ. Code, §§ 3045.1–3045.6) by settling with Barnes without satisfying its lien. The trial court granted Allstate's motion for summary judgment, ruling that Allstate's tender of a check to Barnes payable to Barnes and the Medical Center satisfied its obligations under the HLA. The Medical Center appealed.

The Court of Appeal reversed, holding that Allstate's delivery to Barnes of a check payable to Barnes and the Medical Center for the amount of the hospital lien failed to satisfy its duty under the HLA to satisfy the lien before settling with Barnes. The court noted that, while Allstate may have "constructively delivered" the check to the Medical Center, that did *not* mean that Allstate *actually* made a "payment" to the Medical Center as required under the HLA. The court rejected Allstate's argument that the Medical Center suffered no harm. The court reasoned that "including Barnes as [a] co-payee [on the check] . . . empower[ed] him to negotiate keeping some portion of the amount of the Medical Center's lien for himself. The HLA does not condition the hospital's right to payment on the timing or resolution of a negotiation between the patient and the hospital."

Providers have no private right of action under the CARES Act to enforce health insurers' payment obligations

Saloojas, Inc. v. Aetna Health of Cal., Inc., 80 F.4th 1011 (9th Cir. 2023)

Saloojas, Inc. provides COVID-19 diagnostic testing at a list price published on its website. Aetna is a health insurer that provides COVID-19 tests to its insureds under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Saloojas is not in Aetna's network, so there is no negotiated reimbursement rate for the COVID-19 tests it provides to Aetna's insureds. Saloojas sued Aetna under § 3202(a)(2) of the CARES Act, alleging Aetna paid less than Saloojas's posted cash price for the tests Aetna provided to its insureds. Saloojas sought reimbursement for the difference between what Aetna paid and the full price listed on Saloojas's website. The district

court dismissed Saloojas' complaint, ruling that it had no private right of action under the CARES Act against insurers for violation of § 3202. Saloojas appealed.

The Ninth Circuit affirmed. The court observed that the CARES Act did not expressly create a private right of action, and rejected Saloojas's argument that it had an implied private right of action to seek reimbursement for the full price of its COVID-19 tests. Although the CARES Act states that when there is no negotiated rate an insurer "shall reimburse" the provider for diagnostic testing "in an amount that equals the cash price . . . as listed by the provider," the court explained that such mandatory language alone does not create an implied private right of action. For an implied right of action to exist, there must be "'rights-creating language' that places 'an *unmistakable* focus' on the individuals protected instead of the person regulated." Here, the CARES Act focuses on the regulated party (the insurers), and refers to the providers only as the object of the insurers' obligation. "Accordingly, § 3202(a)(2) of the CARES Act does not contain rights-creating language that would evince Congress's intent to create a private right of action for providers to sue insurers." The court further noted that §3202(b) of the CARES Act includes an enforcement mechanism that is limited to actions by the Secretary of Health and Human Services, which "cuts strongly against a finding of intent to create a private remedy for . . . providers."

MICRA's limitation period applies to third-party's vehicular negligence claim against ambulance driver transporting patient.

Gutierrez v. Tostado (Dec. 1, 2023, H049983)__ Cal.App.5th __ [2023 WL 8296004]

Francisco Gutierrez was rear-ended by an ambulance driven by Uriel Tostado—an emergency medical technician—who was transporting a patient between medical facilities. Nearly two years later, Gutierrez sued Tostado and his employer, a medical transportation company, for negligence. Tostado moved for summary judgment on the ground that Gutierrez's claims were barred by the one-year statute of limitations in MICRA. The trial court granted the motion, and Gutierrez appealed.

The Court of Appeal affirmed in a split decision. Following *Lopez v. American Medical Response West* (2023) 89 Cal.App.5th 336 and *Canister v. Emergency Ambulance Service, Inc.* (2008) 160 Cal.App.4th 388, the majority held that the MICRA limitations period barred Gutierrez's negligence claim because Tostado was a medical provider rendering professional services at the time of the accident. The court explained that MICRA applies to any "negligent act or omission to act by a health care provider in the rendering of professional services." (Code Civ. Proc., § 340.5, subd. (2).) Accordingly, MICRA applied because Gutierrez was injured by Tostado's alleged negligent driving of an ambulance transporting a patient: "transporting a patient in an ambulance qualifies as the provision of medical care . . . [and] driving the ambulance is an integral part of that care." Moreover, the fact that Gutierrez was a third party not receiving medical care was irrelevant because MICRA is not limited to lawsuits by patients or recipients of medical services. The majority reasoned that it would be anomalous if different limitations periods applied to a patient and a third party who were both injured in the same accident.

The dissenting opinion criticized the majority for not following *Lee v. Hanley* (2015) 61 Cal.4th 1225, which construed the legal malpractice limitations period in Code of Civil Procedure section 340.6. *Lee* held that section 340.6 applied only where the attorney violated a professional obligation, rather than a generally applicable nonprofessional obligation. The *Lee* dissent would have held that section 340.6 applied to all negligence claims against an attorney performing professional services, and the dissenting justice in *Gutierrez* faulted the majority for applying the reasoning of the dissent in *Lee*. The *Gutierrez* dissent would apply the same distinction between professional and nonprofessional negligence to the MICRA limitation period that the *Lee* majority adopted. The dissent also reasoned that "it is neither impermissible nor impractical" to apply MICRA's limitations period to some but not all claims involving the same conduct.

GETTING TO KNOW... SHEIRIN GHODDOUCY

by **Sheirin Ghoddoucy**
California Medical Association

Sheirin Ghoddoucy is Senior Legal Counsel for the California Medical Association, with a focus on managed care, provider reimbursement, health care policy, and legislative advocacy. Prior to joining CMA, Ms. Ghoddoucy was a senior attorney at the California Department of Insurance for over a decade, where she worked closely on California's implementation of the Affordable Care Act, as well as a range of legislative and regulatory matters related to health care reform, health insurance regulation and oversight, mental health parity, and health equity, among other health law matters. Prior to that, Ms. Ghoddoucy spent time in private practice focusing on insurance coverage and commercial litigation, as well as corporate transactions.

Ms. Ghoddoucy is a graduate of the University of California, Berkeley, and University of California, Davis School of Law.

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

California Medical Association, Senior Legal Counsel.

2. How long have you held that position?

A little over a year.

3. When did you become a member of CSHA?

In 2022, shortly after joining CMA.

4. Why are you a member of CSHA?

CSHA has proved to be such a great network. I've not only connected with brilliant attorneys in healthcare, I've also met some truly amazing people in this group.

5. When did you become a health lawyer?

In late 2011.

6. Why did you become a health lawyer?

I was hired as part of a brand new team at the California Department of Insurance created to implement the Affordable Care Act. I found health law really interesting and impactful, especially at a regulatory agency focused on increasing consumer access to health care. And 2011, at the beginning of California's health reform implementation efforts, was a particularly dynamic and exciting time opportunity to enter this area of law.

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

I did insurance coverage disputes and commercial litigation at a law firm after law school. The experience and skillsets I gained definitely helped me be a more effective insurance regulator and health care attorney.

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

My work focuses on managed care, coverage, and reimbursement issues primarily because of my regulatory background. I find the work continually engaging because of its ability to meaningfully impact people's access to health care. This area of health law also provides a nice balance of law and policy work. I always love having a chance to help shape health policy.

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

Someone comments on the feline Winston Churchill portrait in my zoom background.

10. What has been the biggest change you have seen in the health care system during your career?

The Affordable Care Act is nearly a decade old now, but it was a real watershed moment in health care. The law is certainly not without its flaws, but it made profound changes in coverage standards that people take for granted today—preexisting condition exclusions, waiting periods, lifetime benefit caps, and other draconian measures that made health coverage inaccessible for many people were routine in health plans before the ACA's reforms.

11. If you could change one California law affecting healthcare, what would it be and why?

I would love to streamline utilization management practices so that

patients and doctors can spend less time trying to navigate each plan's prior authorization requirements and clinical policies, and spend more time focusing on providing care to people who need it.

If you could change one federal law affecting healthcare, what would it be and why?

I'd like to plug some holes in the No Surprises Act, particularly in the independent dispute resolution process and ground ambulances.

What hobbies do you pursue?

I'm a huge cinephile with a special penchant for stories about World War II and, lately, every single series about the opioid crisis. I play classical piano when time allows. I also love rock climbing and skiing, and am trying to make time to get back into them. If anyone is looking for a top roping partner, drop me a line!

What are you watching right now?

I've been on a Cillian Murphy kick lately, so I'm slowly working my way through Peaky Blinders. I also spent a month trying to track down a copy of 28 Days Later.

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

Never meet your heroes (unless they're Cillian Murphy).

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Bailey Bifoss, Parnian Vafaeenia, Jonathan L. Brophy
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