WINTER 2025 VOLUME XXVII, ISSUE 1

CALIFORNIA HEALTH LAW NEWS

THE LATEST DEVELOPMENTS IN CALIFORNIA HEALTH LAW

Street Medicine in CA;
Report on 2024 Legislation;
CA Primary Care Physicians Embrace Concierge Care;
Abortion Shield Laws

CONTENTS

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.

CALIFORNIA HEALTH LAW NEWS

2024-2025 BOARD OF DIRECTORS

Letter from the Editor

Welcome to the first issue of CHLN for 2025!

I'm honored to serve as Co-Editor for the California Society for Healthcare Attorneys and to contribute to this vibrant community of legal professionals navigating the complexities of healthcare law in California. As we step into this new year, with a new administration, our field continues to evolve rapidly, with emerging regulations, technological advancements, and policy shifts shaping the may we adise and advocate.

In this issue, we feature insights on new healthcare delivery models from each side of the spectrum, from street medicine to concierge care. Additionally, we have included as part of our criminalization in healthcare series, an article on abortion shield laws in California. As a roundup we have included a report on the 2024 legislation. We hope you enjoy the first CHLN issue of the new year.

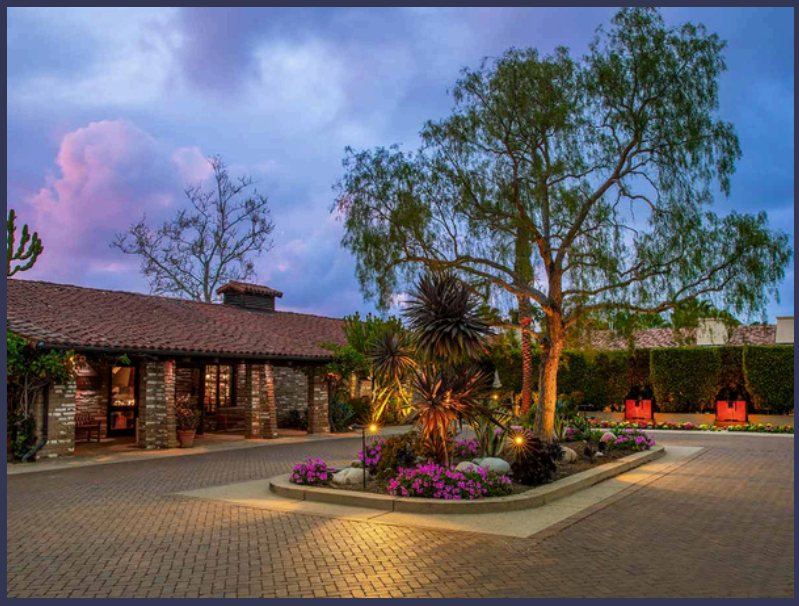
For future issues, please reach out with ideas for articles, whether you wish to be the author or not. We are dedicated to CHLN's continued growth of offering the best and most innovative publications for the California healthcare attorney community. Also, please continue to send us member news items 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 April 4-6 at the Estancia La Jolla Hotel. We hope to see you all there in person!

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

ANNOUNCEMENTS

CSHA ANNUAL MEETING AND SPRING SEMINAR



CSHA is excited to announce the 2025 Annual Meeting & Spring Seminar to be held April 4-6, 2025, at the Estancia La Jolla Hotel and Spa. We offer a full day of MCLE presentations on Friday and mornings only on Saturday and Sunday, leaving afternoons free for you and your family to enjoy La Jolla and its surroundings. Our Friday evening Welcome Reception and Saturday evening Annual Dinner (with entertainment) provide opportunities to network with your fellow health law colleagues! Visit the event webpage to view the full program agenda and to register.

2025-2026 ELECTION RESULTS

CSHA is excited to announce the results of the 2025-2026 Board of Directors election:

President-Elect: Dayna Nicholson, Davis Wright Tremaine LLP

Chief Financial Officer (Appointed by the Board of Directors): David Balfour, Buchalter, A Professional Corporation

Directors at Large (Two-Year Term):

- Karen Kim (2nd Term), Athene Law
- Joel Richlin (2nd Term), U.S. District Court, C.D. Cal
- Jeremy Avila (1st Term), Epstein Becker & Green, P.C.
- John Barnes (1st Term), Davis Wright Tremaine LLP
- Rick Barton (1st Term), Procopio, Cory, Hargreaves & Savitch LLP
- Havi Jogani (1st Term), Dept of Managed Health Care

Please join us in congratulating our new leaders who will assume their respective roles on April 5, 2025!

ANNOUNCEMENTS

EARLY RENEWAL CAMPAIGN WINNERS REVEALED!

We're thrilled to announce the outstanding winners of our recent Early Renewal Campaign! These dedicated individuals have not only ensured their continued membership but have also snagged a fantastic reward – a $100 Amazon gift card each!

Let's give a big round of applause to our winners:

Aimee B. Armsby, CommonSpirit Health
Anna Rich, California Department of Justice
Michael Hodnett, CA Department of Managed Health Care
Andrew Gallacher, Blue Shield of California

Congratulations to the four lucky winners who received an Amazon gift card!

CELEBRATING SUCCESS IN CSHA'S MEMBER-GET-A-MEMBER CAMPAIGN!

The CSHA Member-Get-A-Member Campaign ended on December 31, 2024, and we're excited to recognize those who helped strengthen our community of healthcare attorneys.

Congratulations to the following participants who recruited a new member and received a $25 Amazon gift certificate:

Curtis Leavitt, Kennaday Leavitt PC
Betty Clark, Health Plan of San Joaquin
John Nowakowski, California Correctional Healthcare Services
Richard Barton, Procopio, Cory, Hargreaves & Savitch, LLP

Stay tuned for more exciting opportunities and campaigns!

Getting to Know... Anna R. Buono

Partner in the Litigation practice group at Davis Wright Tremaine LLP.

Why are you a member of CSHA?

I joined CSHA at the suggestion of a health law colleague almost a decade ago when I started working in healthcare litigation. It started as a targeted means to keep up on litigation updates in the health space, but over the years, I've found that this is the best "bang for the buck" group in California for health law. Not only is the educational content that is published and presented timely and substantive, but the network of extraordinary health lawyers is, bar none, the best network of like-minded peers in California.

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

I started as an antitrust lawyer at Heller Ehrman LLP, then expanded to brand integrity/intellectual property matters at Heller and then at Arnold & Porter LLP after Heller's demise.

I initially practiced media law when I started at Davis Wright Tremaine LLP, but then chose to explore more commercial litigation matters, which quickly led to healthcare litigation.

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

I am increasingly focused on two sub-specialties: medical staff/peer review and qui tam actions. Both subjects go to the core of how healthcare providers operate, and both are complex areas with regulatory requirements that are unique and often misunderstood. They also invariably involve very interesting fact patterns, which appeals to me as a story-teller.

What is the biggest challenge in your job?

The work-life balance is the biggest challenge. Sometimes there is no balance, and it can be very hard to accept not being able to "do it all."

What do you consider your greatest achievement in your career?

Every trial win is the greatest achievement. Trial requires so much from you as a lawyer and as a human. It is physically demanding, mentally exhausting, but also exhilarating and even fun! After all you and your clients go through to prepare and present a case at trial, getting the result you want for your client is the absolute best feeling.

CASE SUMMARIES
H. Thomas Watson, Lacey L. Estudillo and Peder K. Batalden
Horvitz & Levy, LLP

Paramedics owe no duty of care to accident victim who repeatedly refuses medical assistance.

Murphy v. City of Petaluma (Nov. 25, 2024, A168012) _ Cal.App.5th _ [2024 WL 4880016] Marites Murphy was involved in a head-on car crash. When paramedics arrived, both Murphy and the other driver were out of their vehicles walking around. Paramedics observed and repeatedly questioned Murphy. They observed no signs of injury, pain, or cognitive impairment, and determined that she was fully responsive and alert. Murphy insisted she was uninjured and did not want or need medical assistance or transportation to a hospital. She continued to refuse treatment even after the paramedics recommended transportation to a hospital for examination by a physician as a precautionary measure. Paramedics concluded that Murphy had the capacity to refuse medical treatment and was exercising her right to do so. Murphy was taken home by her boyfriend, and she later suffered a debilitating stroke while sleeping due to a hypertensive crisis caused by the collision. She sued the city for medical negligence based on the alleged gross negligence of the paramedics who failed to provide her with needed medical treatment and transportation to the hospital.

The trial court granted the city's motion for summary judgment, ruling that the paramedics did not have a duty to provide Murphy with any medical care or transportation to a hospital. Murphy appealed. The Court of Appeal affirmed. The court explained that paramedics, like others, may be liable when their actions increase the risk of harm or when they undertake tasks and perform them negligently. However, the scope of any assumed duty is measured by the nature of the undertaking. Here, the paramedics undertook to assess whether Murphy exhibited an obvious injury and whether she was competent to refuse medical care. Because there was no evidence that the paramedics negligently performed that assessment, and Murphy repeatedly refused medical treatment, the paramedics never assumed any duty to provide Murphy with medical care or transportation to a hospital. Rather, they left Murphy in the same position as they found her.

Under the Hospital Lien Act, hospitals may assert liens against patients' tort recoveries for unpaid emergency services, possibly including amounts in excess of health insurer payments, but such liens must exclude post-discharge services.

Yaffee v. Skeen (Nov. 25, 2024, C097746, C097988) _Cal.App.5th _ [2024 WL 4887969]

David Yaffee sued Joseph Skeen and his employer, KLS Transportation, Inc., for personal injury stemming from a motor vehicle accident. Overruling a defense objection based on Howell v. Hamilton Meats & Provisions, Inc. (2011) 52 Cal.4th 541 and its progeny, the trial court permitted Yaffee's expert to opine on the reasonable value of his past and future medical services based on typical charged amounts without regard to the amounts his health insurer actually paid for that care. The jury returned a verdict in Yaffee's favor, accepting his medical expense damage expert's testimony in full. The trial court then entered a judgment for $3 million in compensatory damages (past and future medical damages, lost income, and noneconomic damages), and $1.6 million in costs and interest. Defendants appealed, contesting the awards.

The Court of Appeal affirmed in part and reversed in part. The court ordered a new trial on past medical damages, rejecting Yaffee's argument that the Hospital Lien Act (HLA), Civil Code section 3045.1, permitted his expert to disregard the limits imposed by Howell and its progeny. The court explained that the HLA allows hospitals to assert liens for the value of required emergency services that are unpaid by uninsured patients.

And while Hospitals cannot assert liens absent an unpaid debt, they may contract with health insurers to preserve their right to assert liens against tort recoveries for the difference between the reasonable value of services and lower negotiated payments. However, the lien must relate to "emergency services," as defined by Health and Safety Code section 1317.1, and cannot include services provided after patients are discharged. The court held that, while Yaffee's hospital had preserved its right to assert an HLA lien in excess of the negotiated payments it received, the trial court committed prejudicial error by allowing Yaffee to recover past medical expense damages measured by the reasonable value of post-discharge services, rather than limiting the damages to amounts actually paid—as Howell requires. The court also reversed the future medical damages award because there was no evidence that Yaffee would probably incur some of those future expenses.

HHS Secretary may not manipulate wage-index for hospital reimbursement rates to assist low-wage hospitals recruit and retain staff

Kaweah Delta Health Care District v. Becerra, _ F.4th _, Nos. 22-55157 & 23-55209, 2024 WL 5063933 (9th Cir. Dec. 11, 2024)

A group of California hospitals sued the Secretary of Health and Human Services (HHS) challenging a policy designed to increase Medicare reimbursements to hospitals operating in geographic areas (primarily rural) where wages are generally low (so-called "low-wage hospitals"). The Medicare Act requires HHS to establish and use a wage index to adjust the national average cost of treatment to reflect actual costs in different localities. HHS's new policy increased the lowest quartile of wage index values, which had the effect of increasing reimbursements to low-wage hospitals to improve their ability to recruit and retain medical staff. To maintain budget neutrality, the policy reduced payments to all other hospitals. A federal district court granted summary judgment for the California hospitals, ruling HHS did not have authority to implement the new policy. HHS appealed and the California hospitals cross-appealed.

The Ninth Circuit affirmed in a split decision. The majority held HHS's new policy violated the Medicare Act's Wage Index Provision, which requires that hospital reimbursement adjustments "reflect" the regional wage level, because the policy intentionally deviated from actual wage-level differences to boost payments to low-wage hospitals. The court rejected HHS's arguments that adjusting the wage index reflects a predictive judgment of regional wage differences that accounts for the time lag in collecting actual wage data, since this data lag would necessarily exist for all hospitals, not just low-wage hospitals. The court further held that the new HHS policy violated the statutory requirement that HHS apply a single wage index equally to all hospitals. The court rejected the Secretary's argument that the new policy was authorized by Medicare Act's Exceptions and Adjustments provision—it would violate the nondelegation doctrine to construe that provision to give the Secretary unconstrained authority to sweep aside the reimbursement scheme approved by Congress.

Hospitals have no duty to disclose to patients emergency room fees other than those specified by statute

Capito v. San Jose Healthcare System, LP (Dec. 23, 2024, S280018) __ Cal.5th __, 2024 WL 5196670

Taylor Capito filed a class action lawsuit against Regional Medical Center San Jose (Regional) after receiving emergency room services. She alleged that Regional violated the Unfair Competition Law (UCL) and the Consumer Legal Remedies Act by failing to give her sufficient notice of an Evaluation and Management Services (EMS) fee that it charged. The trial court sustained Regional's demurrer without leave to amend. Capito appealed the judgment of dismissal. The Court of Appeal affirmed, and then the California Supreme Court granted review.

The Supreme Court also affirmed, holding that hospitals "do not have a duty under the UCL or CLRA, beyond their obligations under the relevant statutory and regulatory scheme, to disclose EMS fees prior to treating emergency room patients." The court reasoned that imposing such a duty would upset "the careful balance of competing interests, including price transparency and provision of emergency care without regard to cost, reflected in the multifaceted scheme developed by state and federal authorities" and thwart the "strong legislative policy to ensure that emergency medical care is provided immediately to those who need it[] and that billing disclosure requirements are not to stand in the way of this paramount objective."

Moreover, requiring hospitals to disclose the wide range of EMS fees that could potentially apply depending on the severity of the patient's condition probably would not "provide reliable notice of actual costs" and "would be misleading because virtually no patients are required to pay the full amount of the EMS Fee." Finally, provided that hospitals comply with statutory disclosure requirements, their failure to provide potential fee range information to ER patients "is unlikely to deceive the public."

The Court approved the decisions in Gray v. Dignity Health (2021) 70 Cal.App.5th 225, Saini v. Sutter Health (2022) 80 Cal.App.5th 105, and Moran v. Prime Healthcare Management, Inc. (2023) 94 Cal.App.5th 166, and disapproved the decisions in Torres v. Adventist Health System/West (2022) 77 Cal.App.5th 500 and Naranjo v. Doctors Medical Center of Modesto, Inc. (2023) 90 Cal.App.5th 1193, many of which were addressed in prior CSHA case bulletins.

Statute imposing stricter expert witness qualifications in hospital emergency care situations applies to physicians who remotely consult in treatment of ER patients.

Charlie L. v. Kangavari (Jan. 2, 2025, B327714) _ Cal.App.5th _, 2025 WL 23756

Charlie L. was brought to a hospital's emergency department, where the attending

physician issued “stat” orders for an X-ray and ultrasound of Charlie’s abdomen. Dr. Peyman Kangavari, an on-call radiologist working remotely, promptly reviewed the images and reported his conclusions to the attending physician, who then discharged Charlie with follow-up instructions. When Charlie’s condition worsened, he returned to the ER and was transported to another hospital for emergency surgery, which was not entirely successful. Charlie filed a medical malpractice lawsuit against numerous healthcare defendants including Dr. Kangavari, whom he claimed had negligently failed to timely diagnose bowel obstructions. Dr. Kangavari moved for summary judgment contending he adhered to the standard of care and did not cause any harm. His motion was supported by the declaration of Dr. John Lieu, a diagnostic radiologist. Charlie’s opposition was supported by declaration of Dr. Ravi Srinivasa, a medical school professor of clinical radiology. The trial court ruled that Health and Safety Code section 1799.110 applied, sustained Dr. Kangavari’s objection that Professor Srinivasa was unqualified under that statute, and granted summary judgment because Charlie lacked a standard-of-care expert. Charlie appealed. The Court of Appeal reversed the summary judgment but accepted some of the trial court’s reasoning. Charlie had argued that section 1799.110 did not apply because Dr. Kangavari was working remotely and on call. The trial court disagreed, ruling that section 1799.110 applies to malpractice actions against physicians who remotely provide medical expertise on an expedited basis as part of an emergency department’s treatment of an emergency department patient. The Court of Appeal agreed: “this is the only conclusion consonant with section 1799.110’s purpose” of “ ‘promot[ing] “the development, accessibility and provision of emergency medical services.” ’ ” The Court of Appeal explained that section 1799.110 relaxed the standard of care for emergency physicians who face unique challenges when making urgent diagnosis and treatment decisions, often without time to review the patient’s medical history, seek consultations, study current medical literature, or reflect on their decisions. The Legislature did not want physicians to be discouraged from taking on emergency posts due to the cost of malpractice insurance based on malpractice claims supported by experts who had no familiarity with providing emergency care. The Court of Appeal concluded that section 1799.110 applies to on-call physicians remotely providing expertise as part of an emergency department because they operate under the same time pressures as emergency physicians and face the same threat of malpractice liability, and expressly disagreed with the contrary holding in Miranda v. National Services, Inc. (1995) 35 Cal.App.4th 894, which the court believed was based on a flawed Legislative history analysis and disregard for the statute’s intended purpose.

Having established that section 1799.110 applied, the Court of Appeal held that neither side had proffered an admissible expert declaration because Drs. Lieu and Srinivasa had failed to attest to substantial professional experience providing emergency medical coverage during the five years preceding the alleged malpractice as required by section 1799.110(c). That holding precluded summary judgment for Dr. Kangavari.

STREET MEDICINE IN CALIFORNIA: OPPORTUNITIES AND CHALLENGES

By: Marisa A. Potter and Alice Hall-Partyka

As the capabilities for how and where health care can be delivered have expanded and there is increased focus on addressing social determinants and root causes associated with health outcomes, regulators, providers and health plans are experimenting with alternative ways to deliver care and improve health outcomes for patients and members. The street medicine model is one crucial way these entities are looking beyond traditional health care settings to reach and better meet the needs of individuals experiencing homelessness, an underserved population. [1] The California Department of Health Care Services ("DHCS"), which administers Medi-Cal, California's Medicaid program, defines street medicine as "a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment." [2] While the term was originally conceived in the 1980s, [3] street medicine has gained attention over the last several years.

Street medicine is particularly critical in California. The point-in-time count of sheltered and unsheltered individuals conducted in 2023 counted more than 180,000 people in the state experiencing homelessness, with California representing 49 percent of all unsheltered persons in the country, [4] and this number likely underrepresents the true number of individuals experiencing homelessness in the state. [5] Individuals experiencing homelessness face numerous barriers that may prevent them from accessing health care services through traditional means. Street medicine aims to bridge this gap by bringing services directly to patients. [6]

Street medicine providers operate through various structures and compensation models. Some street medicine providers provide services entirely free of charge without seeking any reimbursement. [7] [8] Others may contract with and seek reimbursement from health plans, including Medi-Cal managed care plans ("MCPs"), and/or seek grants from municipalities and nonprofit organizations. Such organizations may also contract with larger health care providers or hospitals to provide post-discharge care. As explained in more detail herein, some street medicine providers may seek licensure as a mobile clinic or approval to become a Federally Qualified Health Center ("FQHC").

The services that are provided also vary. While street medicine often includes primary care services, many providers also offer a broader range of other health care services (such as behavioral health services) and related social services (such as Medi-Cal enhanced care management ("ECM") and community supports ("CS")) through a whole person care approach. [9]

I. PUBLIC SUPPORT

There has been significant public support for services targeted at individuals experiencing homelessness, including street medicine, particularly under the Medi-Cal program, which covers low-income individuals and provides such coverage for many individuals experiencing homelessness. With this public support comes various potential revenue streams for street medicine providers – including grants from municipalities and nonprofits and reimbursement from provider organizations, MCPs and the Medi-Cal program (DHCS) directly. The availability of these revenue streams has opened up more opportunities for street medicine providers and the potential for a financially sustainable model of care.

Specifically, street medicine providers may see additional opportunity as MCPs increasingly identify the benefits of contracting with these providers. By contracting with street medicine providers, MCPs and "brick-and-mortar" providers can increase the likelihood that their members and patients regularly access care, and studies show that street medicine can significantly decrease emergency department visits and hospitalizations, mitigate transportation barriers, and reduce the annual cost of care. [10]

DHCS has also encouraged MCPs to target services and improve outcomes for their members experiencing homelessness. [11] MCPs can receive incentive funds for connecting their members to needed housing services and taking an active role in reducing and preventing homelessness through the Housing and Homelessness Incentive Program. [12] [13] Further, DHCS released guidance in 2022, amended and restated earlier this year, that authorized MCPs to contract with street medicine providers and provided a framework for MCPs to apply existing Medi-Cal laws when overseeing these providers. [14]

Street medicine providers may also see additional opportunity through the California Advancing and Innovating Medi-Cal ("CalAIM") program, a multiyear initiative from DHCS intended to improve care and outcomes for Medi-Cal eligible members through integration of social services. [15] Through CalAIM, MCPs are now required to cover and arrange for ECM services for populations of focus, including individuals experiencing homelessness. [16] [17]

CalAIM also encourages plans to contract with community organizations to provide certain community supports, including housing-related services. [18] Street medicine providers are often well-equipped to provide those wraparound services, and many already do so. [19] These services can significantly augment street medicine provider reimbursement compared to traditional clinical services.

II. Compliance & Administrative Challenges

Despite the public and regulatory support for street medicine, the regulatory framework has struggled to adjust to changes in the healthcare delivery model. Laws governing the provision of health care services were not designed for a street medicine model and have been slow to change. Rules that are simple for other medical groups to navigate may create significant legal uncertainty and risk and require innovative solutions for street medicine providers. For instance, street medicine providers may face additional hurdles when complying with state and federal laws relating to storing and dispensing drugs, administering controlled substances, disposing medical waste, or even obtaining operating licenses. These hurdles create additional costs and risks for street medicine providers, serve as a barrier to entry, and generate greater compliance costs as compared to brick-and-mortar clinical sites.

A. Medi-Cal Enrollment Barriers

The Medi-Cal program requirements also present barriers for street medicine providers to participate. While DHCS has promoted street medicine and encouraged MCPs to contract with street medicine providers, as described above, [20] regulations still require that providers maintain a "brick-and-mortar" location to enroll as a Medi-Cal provider, which is a prerequisite for a provider to receive reimbursement from the Medi-Cal program. [21] [22] This physical location requirement continues to serve as a barrier for many street medicine providers who cannot receive payment for fee-for-service services provided to Medi-Cal beneficiaries without maintaining a physical office.

B. Medi-Cal Coverage Redetermination Barriers

Medi-Cal coverage requirements also create significant legal and operational hurdles for street medicine providers. Federal Medicaid laws require that the eligibility of Medi-Cal recipients be redetermined at least every twelve months with respect to circumstances that may change. [23] The redetermination process was temporarily suspended during the COVID-19 pandemic and restarted in 2023. [24] Because the redetermination process generally depends on the state being able to reach members at a physical address, people experiencing homelessness are more likely to lack consistent coverage. [25] DHCS received several income-based and administrative waivers and flexibilities from the Centers for Medicare and Medicaid Services ("CMS") that have allowed California to streamline the enrollment process and re-enroll many individuals in the Medi-Cal program without going through this process. [26] However, even with these changes, more than 1.5 million people lost Medi-Cal coverage in 2024 for "procedural reasons" (e.g., failing to return paperwork). [27]

For the street medicine providers that seek reimbursement through the Medi-Cal program, this process creates an extra hurdle that distracts from the provision of care. Street medicine providers may need separate dedicated resources to help their patients enroll in the Medi-Cal program and fill out the required paperwork in an already resource-pressed environment.

C. Instability of Patients and the Grants Pass Decision

Furthermore, the inherent instability of unsheltered living presents constant challenges for street medicine providers to meet their obligations to provide continuous care for patients simply because patients are often unable to be located and move frequently. For example, a health plan contractual requirement to treat patients a minimum number of times over a given period is likely to be more challenging to satisfy for a provider treating a population experiencing homelessness compared to one that primarily treats housed individuals. In addition to the various barriers to street medicine providers already described herein, the state of street medicine in California has been impacted by the June 28, 2024 United States Supreme Court decision in City of Grants Pass v. Johnson ("Grants Pass"), [28] which transformed communities' capabilities to address homeless encampments throughout the nation. Grants Pass hinged on whether penalizing individuals experiencing homelessness for sleeping outside when no other shelter was available constituted "cruel

and unusual punishment," in violation of the Eighth Amendment of the United States Constitution. [29] The Court found, by a 6-3 majority, in favor of the communities, holding that enforcement of generally applicable laws against camping on public land is permissible under the Constitution. [30]

The day the Grants Pass decision was published, California Governor Gavin Newsom announced that state and local authorities now had "definitive authority to implement and enforce policies to clear unsafe encampments from our streets." [31] He added that "even the most commonsense efforts to clear encampments" [32] had been blocked under prior law. On July 25, 2024, Governor Newsom issued Executive Order N-1-24, which directed state agencies to adopt policies to remove encampments on public property, and encouraged local governments to take the same approach. [33] The Order states that encampments which, "...pose... an imminent threat to life, health, safety, or infrastructure," require "immediate removal." [34] Responses from local officials were immediate, with the majority of these officials indicating they would take prompt actions to clear encampments in their jurisdiction. [35] [36] [37] [38]

Post Grants Pass, with the revival of laws throughout California designed to prohibit sitting and sleeping in public spaces, [39] it seems likely that there will be a related uptick in encampment clearing efforts in many communities. This additional degree of uprooting communities of the unhoused population may make it even more difficult for street medicine providers to track and locate patients and maintain the patient/provider relationship and continuity of care.

III. Street Medicine Pathways to Legitimacy

While street medicine operators often have to operate in grey areas of regulation and licensure, they also have various licensure and designation options available to achieve greater recognition from a regulatory standpoint, improve their financial stability, and make them more attractive as employers. This section will focus on mobile clinic licensure, National Health Services Corps ("NHSC") designation, and FQHC and FQHC "Look-Alike" status, with each one discussed in turn.

A. Mobile Clinic Licensure

1. Overview

Mobile clinics are a subcategory of primary care clinics that use a commercial vehicle to provide medical, diagnostic, and treatment services. They may, but are not required to be, nonprofit organizations and may offer services for free or using a sliding scale based on income. Their statutory and regulatory framework is set forth in California Health & Safety Code Division 2, Chapter 1 (Clinics) and California Code of Regulations Title 22, Division 5, Chapter 7 (Primary Care Clinics), as applicable. Licensure is issued by the California Department of Public Health ("CDPH").

The CDPH Mobile Clinic application is extensive and requires, among other documentation, a cover letter, detailed personal history forms for officers and directors, proof of compliance from the local fire authority, and approvals from the Department of Housing & Community Development and local planning/zoning authorities. [40] Fees for a provider applying for licensure in Los Angeles in 2024 were approximately $3,000, but costs are much

higher if the provider works with a consultant and may reach tens of thousands of dollars. It can take approximately 12 to 24 months to qualify for and obtain mobile clinic licensure.

2. Strategic Considerations

The greatest advantage of mobile clinic licensure is that it allows street medicine providers to directly enroll as Medi-Cal fee-for-service providers, addressing a current barrier for street medicine organizations that lack brick-and-mortar locations, as discussed above. To enroll as a fee-for-service Medi-Cal provider, an entity must have a state-level Medi-Cal enrollment pathway. For street medicine providers, the most likely enrollment options are classification as an in-person clinic site requiring a physical or mobile clinic location. The mobile clinic option is most consistent with the typical street medicine model of care.

B. FQHC Status

FQHCs and FQHC "Look-Alike" organizations are nonprofit or public agency organizations [41] that provide comprehensive primary care services as well as associated enabling services (e.g., transportation and interpretation). [42] FQHCs must provide care on a sliding fee scale and meet the governance requirements set forth below. In exchange, they receive significantly higher reimbursement for health care services compared to the Medi-Cal fee-for-service reimbursement rates. Organizations can become FQHCs and FQHC Look-Alikes in various ways, including through a New Access Point ("NAP"), a federal grant application process run by the Health Resources Services Administration ("HRSA") with a focus on specific health care areas, [43] joining an existing FQHC grantee through a HRSA-approved scope expansion, subcontracting under an FQHC, or obtaining FQHC Look-Alike status, as discussed in more detail below.

1. FQHC Governance Structure

FQHCs must have a board consisting of 9 to 25 members, and over half of those members must be current patients of FQHCs and meet the patient demographics. [44] Additionally, no more than half of the non-patient members may be people who derive more than ten percent of their annual income from the health care industry. [45]

2. FQHC Payment and Programmatic Structure

FQHCs are able to receive heightened Medicare and Medi-Cal reimbursement and access the discounted 340B Drug Pricing Program. FQHCs are a subset of community health centers that come in various forms, each aimed at different sets of patient needs. These include the Health Care for the Homeless ("HCH") programs, which are required to primarily serve unhoused individuals. As of March 2024, 44 HCH grantees operated throughout California, the majority of which were FQHCs. [46]

Street medicine providers that primarily treat uninsured and Medi-Cal patients face constant financial challenges. Both FQHC and FQHC "Look-Alike" designations, which are also granted by HRSA, facilitate significantly higher reimbursement rates for eligible medical services and can bolster a street medicine organization's financial stability. While Medi-Cal typically reimburses providers on a per-service basis, FQHCs and Look-Alikes are paid under a Prospective Payment System ("PPS") or Alternative Payment Methodology ("APM") in California. [47]

The PPS system reimburses on a per visit basis using a rate set based on the FQHC's historical costs and adjusted for inflation. [48] "Visit" is defined as "a face-to-face encounter between an FQHC . . . patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse." [49] APMs must be at least at the PPS rate and provide more flexibility, for example, using bundled payments, capitation, or other payment models. FQHC reimbursement can be over ten times the Medi-Cal rate, so street medicine providers which become or contract under an FQHC will likely see a dramatic increase in payment.

3. A Note on FQHC Look-Alikes

FQHC Look-Alikes are independent entities [50] that meet all applicable FQHC guidelines from HRSA, but do not receive Health Center Program ("HCP") federal grant funding under Section 33 of the Public Health Service Act. [51] Look-Alikes are, however, entitled to the same higher PPS or APM rates as FQHCs. In addition, unlike FQHCs, Look-Alikes are ineligible for 340B drug pricing, federal loan guarantees for capital improvements or malpractice coverage under the Federal Tort Claims Act.

Entities wishing to become FQHC Look-Alikes must submit an application to HRSA. The total time for the look-alike review process, including HRSA's review, site visit, applicant response period, and final determination is typically six to nine months from the application submission to notification of approval or disapproval. [52]

4. Strategic Considerations

FQHC and Look-Alike designations can provide critical financial stability and support for street medicine providers. In addition to the higher rates received for Medicare and Medi-Cal fee-for-service patients, FQHCs benefit in their relationships with MCPs, as MCPs are required to contract with FQHCs in their service area if the FQHC is willing to accept the plan's payment rate and terms, which must also be equal to or greater than the PPS rate. [53]

FQHCs and FQHC Look-Alikes also are automatically deemed to be in a Health Professional Shortage Area ("HPSA"), which enables the ability to apply for a NHSC designation (as discussed below), with its related recruitment advantages (e.g., loan repayment benefits). [54] While FQHC designations include many attractive benefits, the required governance structure and related compliance programs make the application and ongoing compliance challenging. Many street medicine providers are affiliated with larger health care organizations or academic medical centers. The emphasis on FQHC independence presents an issue for such entities, as it requires them to largely sever ties to (and control by) a larger parent entity. The tradeoff between a street medicine organization's sponsorship and support in exchange for the heightened reimbursement of being an FQHC must be carefully considered.

C. National Health Services Corps ("NHSC") Site Designation

1. Overview

The NHSC site designation is available for organizations that provide outpatient, comprehensive primary care services and allows their clinicians to access enhanced loan repayment and scholarship programs. The NHSC program is run by HRSA. Applicants must be located in a HRSA-designated HPSA, which are areas with shortages of primary, dental, or mental health care providers. [55]

The NHSC Reference Guide [56] specifically addresses standalone mobile units/clinics that provide primary care services to people located in an HPSA more than half of the time. Interested mobile unit applicants must provide a list of the locations the unit stops at, or an attestation stating that at least 50 percent of the unit's stops are in HPSAs.

One of the more significant NHSC requirements is that the provider must offer a sliding fee scale for patient services for at least six consecutive months before it applies (and continuously thereafter) and provide underlying data to support this. Providers that never charge for services (free clinics) are exempt from this requirement and must provide data supporting that no patients are charged or billed, nor is anyone denied services due to inability to pay.

2. Strategic Considerations

NHSC designation primarily helps street medicine providers with clinician recruitment and retention. Street medicine sites that are NHSC-qualified may offer loan repayment and scholarship programs that make them more attractive to clinicians interested in working with vulnerable populations. The NHSC scholarship program awards up to four years of full-time enrollment in a primary care program in exchange for a minimum of two years of full-time service at an NHSC-approved site. [57] The NHSC loan repayment program is available to graduates in allopathic and osteopathic medicine, physician assistant studies, nursing, and dentistry and provides up to $120,000 in loan repayment funds. [58]

One downside of the NHSC designation is that it is attributed to one specific location at a time, so street medicine providers that operate in various counties must apply for each location individually. NHSC also does not provide formal licensure or additional legitimacy related to the provision of health care services, and so street medicine providers designated with NHSC may want to additionally seek mobile clinic licensure and/or FQHC/Look-Alike status.

III. Conclusion

Street medicine providers fill a critical gap in health care delivery and serve some of the most hard-to-reach patients, such as those experiencing homelessness. In recent years, street medicine has gained attention and regulators, including DHCS, have expanded programs pertaining to social determinants of health and vulnerable populations. While these changes have not resolved all the unique operational and compliance challenges faced by street medicine providers, this public support has increased the pathways that street medicine providers have for funding and licensure and, in doing so, opened up more opportunities for providers to adopt these delivery methods and treat unhoused populations.

Endnotes

[1] See, e.g., Robin Buller, Ph.D., State of Street Medicine in California, California Health Care Foundation ("CHCF"), (June 2023); hereafter, "CHCF Issue Brief"), https://www.chcf.org/wp-content/uploads/2023/03/StateofStreetMedicineCA.pdf.
[2] DHCS, All Plan Letter ("APL") 24-001: Street Medicine Provider: Definitions and Participation in Managed Care, ("DHCS APL 24-001") (January 12, 2024), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-001.pdf.
[3] National Health Care for the Homeless Council, Street Medicine: Medical Outreach for Unsheltered Persons (accessed Oct. 17, 2024), https://nlihc.org/sites/default/files/NHCHC_What-is-Street-Medicine.pdf.
[4] U.S. Department of Housing and Urban Development, The 2023 Annual Homelessness Assessment Report (AHAR) to Congress 16 (Dec. 2023), https://www.huduser.gov/portal/sites/default/files/pdf/2023-AHAR-Part-1.pdf.
[5] See, e.g., National Homelessness Law Center, Don't Count on It, How the HUD Point-in-Time Count Underestimates the Homelessness Crisis in America 6-7 (2017), https://homelesslaw.org/wp-content/uploads/2018/10/HUD-PIT-report2017.pdf.
[6] See, generally, CHCF Issue Brief, supra note 1.
[7] See, e.g., University of Southern California ("USC") Keck School of Medicine, Street Medicine (accessed Oct. 17, 2024), https://keck.usc.edu/family-medicine/patient-care/street-medicine/#:~:text=Street%20Medicine%20serves%20the%20homeless,and%20drawing%20blood%20for%20testing.
[8] University of California, Los Angeles ("UCLA") Health, Homeless Healthcare Collaborative in Los Angeles (accessed Oct. 17, 2024), https://www.uclahealth.org/programs/hhc.
[9] See, e.g., CHCF Issue Brief, supra note 1.
[10] Kaufman et al., The Role of Street Medicine and Mobile Clinics for Persons Experiencing Homelessness: A Scoping Review, Int. J Environ Res Public Health. 2024 Jun;21(6):760.
[11] See, e.g., DHCS APL 24-005: California Housing and Homelessness Incentive Program, https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-005.pdf.
[12] Id.
[13] DHCS APL 24-001, supra note 2.
[14] Id. DHCS APL 24-001 states that providers are not required to meet the credentialing requirements set forth in APL 22-013 to be included in a MCP's network. MCPs are, however, required to vet street medicine providers not directly enrolled with DHCS, and the APL sets forth various considerations for this process, such as their prior experience providing these services, capabilities to comply with reporting and oversight requirements, and the ability to submit claims using standard protocols.
[15] See DHCS CalAIM 1115 Demonstration & 1915(b) Waiver (accessed October 17, 2024), https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx.
[16] DHCS APL 21-012: Enhanced Care Management Requirements, (September 15, 2021), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-012.pdf.
[17] DHCS Medi-Cal Transformation: Enhanced Care Management (accessed Oct. 17, 2024), https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-ECM-a11y.pdf.
[18] See DHCS, CalAIM Homelessness or Housing Instability (accessed Oct. 17, 2024), https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-HHI-a11y.pdf.
[19] CHCF Issue Brief, supra note 1, at 3. For instance, street medicine teams may use team-based models that facilitate care coordination, linkages to housing and shelter, and emotional support from peers.
[20] See, e.g., DHCS APL 24-001, supra note 2.
[21] Cal. Code Regs. Tit. 22, §§ 51000.3 & 51000.60.
[22] DHCS APL 22-013: Provider Credentialing / Re-Credentialing and Screening / Enrollment APL Frequently Asked Questions, No. 17 8-9 (March 17, 2022), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-013-FAQ.pdf.
[23] 45 C.F.R. § 438.916(a).
[24] CHCF, Medi-Cal Renewal for People Experiencing Homelessness: Toolkit (Sept. 14, 2023), https://www.chcf.org/publication/medi-cal-renewal-for-people-experiencing-homelessness-toolkit/.
[25] Id.
[26] DHCS, Issue Brief: California's Journey with Medi-Cal Redeterminations (March 2024), https://www.chhs.ca.gov/wp-content/uploads/2024/03/California-USDS-Issue-Brief-March-2024.pdf.
[27] CHCF, Key Takeaways from Medi-Cal Redetermination Data (Aug. 14, 2024), https://www.chcf.org/publication/key-takeaways-medi-cal-redetermination-data-june-august-2023/#related-links-and-downloads.
[28] City of Grants Pass v. Johnson, 144 S. Ct. 2202 (2024).
[29] Id. at 2204-2206.

[30] In doing so, the United States Supreme Court overturned six years of case law in the Ninth Circuit (Martin v. Boise, 902 F.3d 1031 (9th Cir. 2018) ("Martin"). Under Martin, communities could not criminalize sleeping outside on public land if there was not enough shelter or alternative housing space available. Martin significantly affected the way California cities could address homelessness encampments. Many jurisdictions revised or suspended laws against camping in public spaces because they could not provide sufficient alternative shelter.
[31] Governor Newsom's Statement on Supreme Court Homeless Encampments Decision (accessed Nov. 6, 2024), https://www.gov.ca.gov/2024/06/28/governor-newsom-statement-on-supreme-courts-homeless-encampments-decision/.
[32] Id.
[33] Executive Order N-1-24 (2024) (accessed Nov. 6, 2024), https://www.gov.ca.gov/wp-content/uploads/2024/07/2024-Encampments-EO-7-24.pdf.
[34] Id. at 2. However, Executive Order N-1-24 (2024) did not set a specific timeline for agencies to take action nor set forth a way to address where individuals removed from such encampments should go.
[35] Mayor London Breed of San Francisco announced that "we will not allow those who reject offers of help to remain where they are [on the streets]." Mayor London N. Breed on the Supreme Court Decision in Grants Pass (June 28, 2024), (accessed Nov. 6, 2024), https://www.sf.gov/news/mayor-london-n-breed-supreme-court-decision-grants-pass#:~:text=%E2%80%9CWe%20will%20continue%20to%20offer,to%20remain%20where%20they%20are.
[36] Mayor Karen Bass of Los Angeles criticized the Grants Pass decision, describing it as "disappointing" and adding that the only way to address the homelessness crisis is to "bring people indoors with housing and supportive services." Mayor Bass Slams Supreme Court's Ruling to Allow Failed Homeless Policies Across the Nation (June 28, 2024), https://mayor.lacity.gov/news/mayor-bass-slams-supreme-courts-ruling-allow-failed-homeless-policies-across-nation#:~:text=Mayor%20Karen%20Bass-,Mayor%20Bass%20Slams%20Supreme%20Court's%20Ruling%20To,Homeless%20Policies%20Across%20The%20Nation&text=LOS%20ANGELES%20%E2%80%93%20Today%2C%20the%20United,other%20safe%20place%20to%20.
[37] In Long Beach, California, police officers "now have discretion to enforce ordinances restricting camping or sleeping in public places." Sternfield, Marc, KTLA News, Santa Monica Could Ban Sleeping in Public in Homeless Crackdown (August 27, 2024), https://ktla.com/news/local-news/santa-monica-could-ban-sleeping-in-public-in-homeless-crackdown/.
[38] The Folsom, California Police Department kicked off its homeless outreach team to enforce bans on unlawful camping on July 2, 2024, four days after the decision. Muegge, Alex, ABC News, Folsom Police Will Enforce Homeless Camping Bans on Public Property, Chief Says (July 2, 2024), https://www.abc10.com/article/news/local/folsom-police-to-enforce-homeless-camping-bans/103-d187d937-3e28-465d-820b-dc8ae3c75917.
[39] For example, on July 8, 2024, the Ninth Circuit overturned an injunction that had prohibited San Francisco from enforcing its laws against sitting, sleeping, or lying on public property. Coalition on Homelessness v. San Francisco, No. 23-15087, (9th Cir. 2024) (unpublished memorandum), https://content.sfstandard.com/wp-content/uploads/2024/07/document-4.pdf.
[40] CDPH, Primary Care Clinic - Consolidated Mobile Initial Application Checklist, (accessed November 12, 2024), https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/PCC-Consolidated-Mobile-Initial-Provider-Checklist.aspx.
[41] HRSA, Health Center Program Compliance Manual ("HRSA Compliance Manual") 10, (accessed November 12, 2024), https://bphc.hrsa.gov/compliance/compliance-manual/.
[42] FQHCs are governed by federal law, including 42 U.S.C. 254b (Health Centers) and corresponding regulations at 42 CFR Part 51c (Grants for Community Health Services), with additional rules set forth in each state to address Medicaid managed care contracting requirements (e.g., Cal. Welf. & Inst. Code § 14087.325).
[43] HRSA issued its latest New Access Points (NAP) funding opportunity in August 2024 with a close date of September 30, 2024, https://grants.gov/search-results-detail/349046.
[44] 42 C.F.R. § 51c.304.
[45] 42 C.F.R § 51c.204.
[46] CHCF, California's Health Care for the Homeless Grantees, p. 5 (Mar. 25, 2024), https://www.chcf.org/publication/californias-health-care-homeless-grantees/#related-links-and-downloads.

[47] CHCF, Medi-Cal Explained: How Health Centers Are Paid (May 2022), https://www.chcf.org/wp-content/uploads/2022/05/MediCalExplainedHealthCentersPaid.pdf.
[48] Cal. Welf. & Inst. Code § 14132.100.
[49] Cal. Welf. & Inst. Code § 14132.100(g)(1).
[50] HRSA, Compliance Manual, supra note 38, at 11 ("FQHCs cannot be owned, controlled, or operated by another entity.").
[51] HRSA, Compliance Manual, supra note 38, at 91.
[52] HRSA, Look-Alike Initial Designation Application Instructions 48-49 (Aug. 13, 2020), https://bphc.hrsa.gov/sites/default/files/bphc/about/lal-id-instructions.pdf.
[53] Cal. Welf. & Inst. Code § 14087.325.
[54] HRSA, What is Shortage Designation? (June 2023), https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation.
[55] Id.
[56] HRSA, National Health Service Corps Site Reference Guide (May 2024) 40, https://nhsc.hrsa.gov/sites/default/files/nhsc/nhsc-sites/nhsc-site-reference-guide.pdf.
[57] HRSA, NHSC Scholarship Program Overview (June 2024), https://nhsc.hrsa.gov/scholarships/overview.
[58] HRSA, National Health Service Corps Students to Service Loan Repayment Program Fiscal Year 2025 Application and Program Guidance (August 2024), https://nhsc.hrsa.gov/sites/default/files/nhsc/loan-repayment/nhsc-students2service-lrp-application-program-guidance.pdf.

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Report on 2024 Legislation

By Sheirin Ghoddoucy,
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The California Legislature passed many new laws in 2024 affecting health care, including several bills pertaining to health care coverage, drug prescribing, public health, workforce, and office safety. Below are brief descriptions of noteworthy healthcare-related bills enacted during the second year of California's 2023-24 legislative session. The full text of each Assembly Bill (AB) and Senate Bill (SB) is available at http://leginfo.legislature.ca.gov/. Urgency bills are listed with the date they became effective. All other measures take effect Jan. 1, 2025.

ALLIED HEALTH PROFESSIONALS

AB 2730 (Lackey) – Sexual assault: medical evidentiary examinations
Existing law defines when a physician assistant or nurse is a qualified health care professional authorized to conduct sexual assault forensic medical examination (SAFME) and treatment, including a requirement that the provider work in consultation with a physician and surgeon. This law removes the requirement that the consulting physician and surgeon be a practitioner who conducts SAFME examination or treatment, and replaces it with requirement that the consulting physician and surgeon be currently licensed. Also adds certified nurse-midwives to the list of qualified healthcare professionals, provided they work in consultation with a currently licensed physician and surgeon.
(Amends Penal Code §13823.5)

SB 339 (Wiener) – HIV preexposure prophylaxis and postexposure prophylaxis
Authorizes a pharmacist to furnish up to a 90-day course of preexposure prophylaxis (PrEP), or preexposure prophylaxis (PEP) beyond a 90-day course. Also authorizes a pharmacist to furnish PrEP beyond the 90-day limit if the patient receives specified testing and follow up care consistent with Centers for Disease Control (CDC) guidelines, including HIV, renal function, hepatitis B, hepatitis C, sexually transmitted diseases, and pregnancy for individuals of childbearing capacity. Requires health plans and health insurers to cover all PrEP and PEP furnished by a pharmacist, and all related pharmacist services and testing ordered by a pharmacist. Urgency bill effective Feb. 6, 2024.
(Amends Business and Professions Code §4052.02; amends Health and Safety Code §1342.74; amends Insurance Code §1342.74; amends Welfare and Institutions Code §14132.968)

SB 1451 (Ashby) – Professions and vocations
Prohibits anyone other than a licensed physician and surgeon from using “doctor,” “physician,” “Dr.,” “M.D.,” “D.O.,” or any other terms or letters implying the person is a physician, in a health care setting. Extends pharmacist test-to-treat authority for COVID to Jan. 1, 2026. For purposes of advance practice nurse practitioner (NP) certification under AB 890 (2020), this law prohibits limiting the NP’s clinical experience to a single category of practice, and allows an NP with at least 3 full-time equivalent years or 4,600 hours of direct patient care within the past 5 years to be deemed to have met the transition-to-practice requirements. Eliminates the requirement for NPs practicing independently to inform patients of their right to see a physician or to use specific phrases to communicate their non-physician status to Spanish language speakers. Adjusts the initial licensure period for resident physicians and surgeons to 26 months for those licensed after Jan. 1, 2025. For residents who have not completed at least 36 months of approved training at initial renewal, allows licensee to renew if enrolled in approved training program at time of renewal (only applicable to physician and surgeon licenses first issued on or after Jan. 1, 2022).
(Amends Business and Professions Code §§115.4, 115.5, 115.6, 135.4, 1926, 2054, 2837.101, 2837.103, 2837.104, 2837.105, 3765, 4052.04, 4602, 4621, 7423, 8593, 8593.1, 9880.1, and 19237; adds Business and Professions Code §§2097.5, 4069, and 9880.5; repeals Business and Professions Code §1905.2)

CLINICAL LABORATORIES

AB 2107 (Chen) – Clinical laboratory technology: remote review
Allows pathologists to remotely review digital materials (such as lab data, results, and images) under a clinical laboratory's primary Clinical Laboratory Improvement Amendments (CLIA) certificate, without requiring separate licenses or registrations for the remote locations; contingent on the California Department of Public Health (CDPH) determining that the authorization conforms to federal law by Jan. 1, 2026, in consultation with the federal Centers for Medicare and Medicaid Service.
(Amends Business and Professions Code §1265; adds Business and Professions Code §1265.2; repeals Business and Professions Code §1265.3)

CONFIDENTIAL INFORMATION

SB 1223 (Becker) – Consumer privacy: sensitive personal information: neural data
Adds a consumer's neural data to the definition of "sensitive personal information" for purposes of the California Consumer Privacy Act of 2018 (CCPA), which grants consumers specified rights and protections over their personal information collected by a business that is not subject to HIPAA (CCPA exempts covered entities under HIPAA). Defines "neural data" to mean information that is generated by measuring the activity of a consumer's central or peripheral nervous system, and that is not inferred from nonneural information.
(Amends Civil Code §1798.140870)

CONSENT

AB 866 (Rubio) – Juveniles: care and treatment
Authorizes a dependent child of the juvenile court who is 16 years of age or older to consent to receive medications for opioid use disorder from a licensed narcotic treatment program as replacement narcotic therapy without the consent of their parent, guardian, person standing in loco parentis, or social worker, and without a court order to the extent permitted by federal law.
(Amends Welfare and Institutions Code §369)

DRUG PRESCRIBING AND DISPENSING

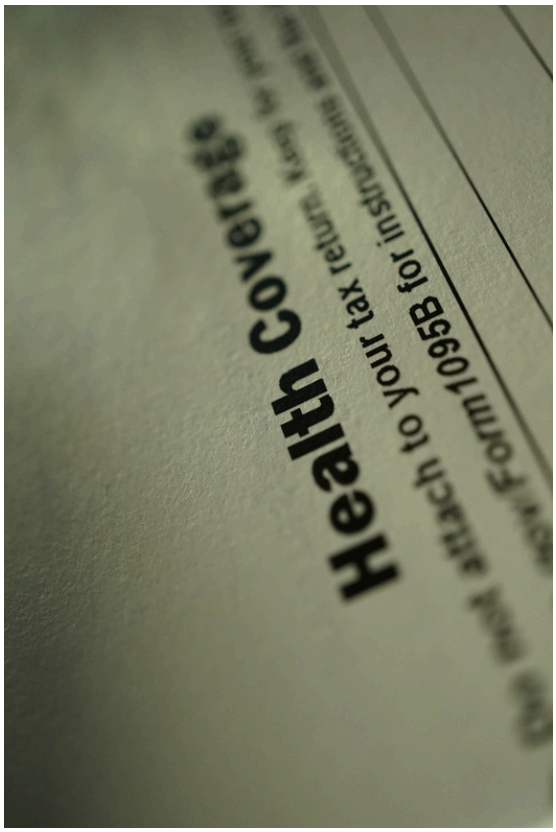
AB 1902 (Alanis) – Prescription drug labels: accessibility
Requires pharmacies to provide accessible prescription labels upon request at no additional cost for patients with vision impairment (blind, low vision, or otherwise print-disabled).
(Amends Business and Professions Code §4076.6; adds Business and Professions Code §4076.8)

AB 2018 (Rodriquez) – Controlled substances: fenfluramine
Removes fenfluramine from the list of Schedule IV–controlled substances under the California Uniform Controlled Substances Act, in alignment with the federal Controlled Substances Act, under which fenfluramine was descheduled in Dec. 2022. Removes fenfluramine from the list of controlled substances that are a crime to possess or sell. As a result of the state descheduling, prescribers will no longer need to consult the CURES database before prescribing fenfluramine.
(Amends Health and Safety Code §§11057 and 11375)

AB 2115 (Haney) – Controlled substances: clinics
Allows a practitioner authorized to prescribe a narcotic drug at a nonprofit or free clinic to dispense the narcotic drug from clinic supply for the purpose of relieving acute withdrawal symptoms while arrangements are being made for referral for treatment; the clinic dispensing the narcotic must comply with specified reporting, labeling, and recordkeeping requirements. Authorizes a practitioner to dispense a Schedule II–controlled substance (which may be from a hospital pharmacy inventory) directly to an ultimate user in amount not to exceed a 72-hour supply to initiate maintenance or detox treatment. Removes levo-alpha-acetylmethadol (LAAM) from list of authorized medications for use in narcotic replacement therapy by narcotic treatment programs (NTPs). Directs the Department of Health Care Services (DHCS) to update its NTP regulations to comply with federal rules. Urgency statute effective Sep. 30, 2024.
(Amends Penal Code §849)

SB 607 (Portantino) – Controlled substances
Expands the requirement for a prescriber to discuss specified information about opioids to any patient before directly dispensing or issuing the first prescription for a controlled substance containing an opioid in a single course of treatment (under previous law, disclosure was only required for minor patients). Required disclosures pertain to risks of overdose and addiction, dangers of an opioid with a benzodiazepine, alcohol, or another central nervous system depressant, and any other information required by law. Deletes previous exception for treatment for chronic intractable pain. Retains other exceptions for prescribing to hospital, skilled nursing facility, intermediate care facility, home health agency, or hospice patients; for treatment for terminal illness or substance use disorder; for patients receiving emergency care or emergency surgery; or in instances where in the prescriber's professional judgment, providing the required disclosures would be detrimental to patient health or safety, or in violation of patient rights regarding confidentiality.
(Amends Health and Safety Code §11158.1)

SB 1468 (Ochoa Bogh) – Healing arts boards: informational and educational materials for prescribers of narcotics: federal "Three Day Rule"
Requires each board that licenses prescribers to develop and annually disseminate to each licensee informational and educational material regarding the "Three Day Rule," and to post that material on their internet website, in order to increase awareness of medication-assisted treatment (MAT) pathways. (Rule allows prescribers not in a narcotic treatment program to prescribe up to three days' worth of MAT for opioid use disorder.) Also requires the Medical Board to annually disseminate materials to acute care hospitals in the state.
(Adds Business and Professions Code Article 10.8, Chapter 1, Division 2 (commencing with §750))



HEALTH CARE COVERAGE AND MANAGED CARE

AB 1842 (Reyes) – Health care coverage: Medication-assisted treatment

Requires a health care service plan or health insurer offering an outpatient prescription drug benefit to provide coverage for at least one medication approved by the U.S. Food and Drug Administration in each of the following categories without prior authorization, step therapy, or utilization review: (1) medication for the reversal of opioid overdose, including a naloxone product or another opioid antagonist; (2) medication for the detoxification or maintenance treatment of a substance use disorder, including a daily oral buprenorphine product; (3) a long-acting buprenorphine product; (4) a long-acting injectable naltrexone product.
(Adds Health and Safety Code §1342.75; adds Insurance Code §10123.1935)

AB 2105 (Lowenthal) – Coverage for PANDAS and PANS

Requires health plans and health insurers to cover the diagnosis and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS), when prescribed or ordered by a treating physician and medically necessary under current nationally recognized clinical practice guidelines, as specified. Requires coverage for specified treatment, including antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines, plasma exchange, and intravenous immunoglobulin therapy. Prohibits plans and insurers from imposing a higher cost-sharing for PANDAS and PANS than other benefits, and from denying or delaying coverage based on previous treatment or different diagnostic names.
(Adds Health and Safety Code §1367.38; adds Insurance Code §10123.38)

AB 2132 (Low) – Health care services: tuberculosis

Requires a patient who is 18 years of age or older receiving health care services where primary care services are provided, to be offered tuberculosis (TB) screening, if TB risk factors are identified and to the extent these services are covered under the patient's health care coverage; excludes emergency department of a general acute care hospital. Requires a health care provider to offer or refer a patient for follow-up care if a patient tests positive for TB. Provides that a health care provider shall not be subject to disciplinary action or civil or criminal liability due to the provider's failure

AB 2258 (Zbur) – Health care coverage: cost sharing

Prohibits health plans and health insurers from imposing cost-sharing for any items or services that are integral to the provision of preventive care services, including but not limited to cervical and colorectal cancer screenings, HIV prophylaxis (PrEP and PEP), and home test kits for sexually transmitted diseases; prohibition applies regardless of whether the integral item or service is billed separately from a preventive care item or service. Prohibits health plans and health insurers from imposing cost sharing for office visits associated with a preventive care service if the primary purpose of the office visit is the delivery of the preventive care service, and the preventive service and office visit are not billed separately or tracked as separate encounters.
(Amends Health and Safety Code §1367.002; amends Insurance Code §10112.2)

AB 2843 (Petrie-Norris) – Health care coverage: rape and sexual assault

Requires health plans and health insurance policies issued, amended, renewed, or delivered on or after July 1, 2025, to provide coverage without cost sharing for emergency room medical care and followup treatment following a rape or sexual assault for the first 9 months after an enrollee initiates treatment, as specified. Prohibits a health plan or health insurer from requiring an enrollee or insured to file a police report, charges to be brought against an assailant, or an assailant to be convicted of rape or sexual assault, as a condition of providing coverage.
(Adds Health and Safety Code §1367.37; adds Insurance Code §10123.211)

AB 3059 (Weber) – Human Milk

Designates medically necessary pasteurized donor human milk obtained from a licensed tissue bank as a basic health care service; as such, health plans will be required to cover pasteurized donor human milk when medically necessary, subject to the terms and conditions of the plan. Exempts the storage or distribution of pasteurized donor human milk that was obtained from a licensed tissue bank, by a general acute care hospital, from tissue bank licensure requirements.
(Amends Health and Safety Code §§1635.1 and 1648; adds Health and Safety Code §1367.624; adds Insurance Code §10123.864)

SB 1120 (Becker) – Health care coverage: utilization review

Requires a health plan or disability insurer using artificial intelligence (AI), algorithm, or other software tools for utilization review or management based in whole or in part on medical necessity to comply with specified standards, including requiring the AI, algorithm, or software tool to base medical necessity determinations on the enrollee's clinical history and individualized clinical circumstances as presented by the requesting provider, and to adhere to other specified criteria relating to nondiscrimination, fairness and equity, regulatory audits, oversight policies and procedures, privacy and permitted uses of patient data, periodic review of tool's accuracy and reliability, patient safety, and preservation of the health care provider's role in making health care decisions. Prohibits an AI, algorithm, or other software tool from denying, delaying, or modifying health care services based in whole or in part on medical necessity; requires such adverse determinations to be made only by a licensed physician or a licensed health care professional competent to evaluate the specific clinical issues involved in the request.
(Amends Health and Safety Code §1367.01; amends Insurance Code §10123.135)

HEALTH CARE FACILITIES AND FINANCING

AB 869 (Wood) – Hospitals: seismic safety compliance

Authorizes a Distressed Hospital Loan Program recipient, a small hospital, a rural hospital, a critical access hospital, or a health care district hospital, to seek approval from the Department of Health Care Access and Information (HCAI) for a delay to the Jan. 1, 2030, compliance deadline by up to 3 years. Requires hospitals seeking a delay to submit a seismic compliance plan, and, if necessary, a Nonstructural Performance Category-5 evaluation report.

(Amends Health and Safety Code §130065; adds Health and Safety Code §§130065.1, 130065.15, 130078.5, and 130078.6)

AB 2293 (Mathias) – Joint powers agreements: health care services

Until Jan. 1, 2034, authorizes private, nonprofit mutual benefit corporations formed for purposes of providing health care services, to join a joint powers authority (JPA) or enter into a joint powers agreement with one or more public entities established under the Joint Exercise of Powers Act. Deems the JPA formed under this law to be a public entity, but prohibits the JPA from employing physicians and surgeons, charging for professional services rendered by physicians and surgeons, or otherwise engaging in the practice of medicine.

(Adds and repeals Government Code §6538.6)

AB 3161 (Bonta) – Health facilities: patient safety and antidiscrimination
Requires health facilities to include anonymous reporting in their patient safety event reporting systems, analyze safety events by sociodemographic factors to identify disparities, address racism and discrimination in patient care, and submit biannual patient safety plans to CDPH starting in 2026, with penalties for noncompliance and public access to the plans online.
(Amends Health and Safety Code §1279.6)

SB 963 (Ashby) – Hospitals: self-identification procedure: human trafficking or domestic violence
Requires all general acute care hospitals with an emergency department to adopt and implement policies and procedures to facilitate the self-identification of an emergency department patient as a victim of human trafficking or domestic violence to hospital personnel. Requires policies and procedures to meet certain requirements, including providing for patient confidentiality and facilitating a reasonably prompt, private, and voluntary interview of the patient by medical personnel, for the purpose of providing certain information to the patient relating to local services and resources for victims of human trafficking or domestic violence.
(Adds Health and Safety Code §1281.5)

SB 1300 (Cortese) – Health facility closure: public notice: inpatient psychiatric and perinatal services
Increases the notice period required before proposed closure or elimination of the supplemental service of inpatient psychiatric unit or a perinatal unit from 90 days to 120 days. Requires the health facility to provide public notice of the proposed elimination of the supplemental service of either inpatient psychiatric unit or perinatal unit, and conduct at least one noticed public hearing within 60 days of the notice of proposed elimination.
(Amends Health and Safety Code §1255.25)

MEDI-CAL

AB 1005 (Alvarez) – In-home supportive services: terminal illness diagnosis
Before a Medi-Cal beneficiary diagnosed with a terminal illness is discharged from an acute care hospital, requires a hospital's designated case manager or discharge planner to evaluate the patient's likely need for posthospital services and ability to access those services, and to offer and provide information about the In-Home Supportive Services (IHSS) program and application process. If the patient seeks to apply for IHSS program services, the hospital case manager or discharge planner must communicate the patient's interest in applying to their primary care physician to support timely completion of the health care certification form.
(Adds Health and Safety Code §442.9)

AB 1316 (Irwin) – Emergency services: psychiatric emergency medical conditions
Revises the definition of "psychiatric emergency medical condition" to make the definition applicable regardless of whether the patient is voluntary, or is involuntarily detained for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment, under prescribed circumstances. Requires Medi-Cal to cover emergency services and care necessary to treat an emergency medical condition, including poststabilization care services required under federal law, emergency room professional services, and facility charges for emergency room visits. Also requires Medi-Cal to cover emergency services necessary to relieve or eliminate a psychiatric emergency medical condition, regardless of whether the beneficiary is voluntary or involuntarily detained for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment.
(Amends Health and Safety Code §§1317.1, 1317.2a, 1317.4a, 1317.4b, and 1317.7; adds Welfare and Institutions §14132.025)

AB 2340 (Bonta) – Medi-Cal: EPSDT services: informational materials
Requires the DHCS to create and regularly update clear, culturally relevant informational materials explaining the scope of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services under Medi-Cal for individuals under 21, including content tailored for youth aged 12 to 21, and to test the quality and clarity of translations with Medi-Cal beneficiaries.
(Adds Welfare and Institutions Code Article 4.12, Ch. 7, Division 9, Part 3 (commencing with §14149.95))

SB 136 (Committee on Budget and Fiscal Review) – Medi-Cal: managed care organization provider tax
Increases the tax amount for managed care plans in Medi-Cal tax tier II (1.25 million to 4 million enrollees) to $205 per enrollee for calendar years 2024-2026.
(Amends Welfare and Institutions Code §14199.85)

SB 1131 (Gonzalez) – Medi-Cal providers: family planning
Requires a site certifier of a primary care clinic or affiliate primary care clinic to be a clinician who oversees the provision of Family Planning, Access, Care, and Treatment (Family PACT) Program services and authorizes certain clinic corporations to enroll multiple, but no more than 10, service addresses under one site certifier. Authorizes DHCS to elect to not disenroll an individual or entity as a program provider following the revocation, suspension, or loss of a license, certificate, or other approval to provide health care based solely on conduct that is not deemed to be unprofessional conduct under California law. Subject to obtaining any necessary federal approvals.
(Amends Welfare and Institutions Code §24005; adds Welfare and Institutions Code §24006)

SB 1385 (Roth) – Medi-Cal: community health workers: supervising providers
Requires a Medi-Cal managed care plan, no later than July 1, 2025, to adopt policies and procedures to effectuate a billing pathway for supervising providers to claim for the provision of community health worker services to enrollees during an emergency department visit and as an outpatient follow-up to an emergency department visit. Policies and procedures must be consistent with guidance developed by DHCS for billing for community health worker services provided to Medi-Cal fee-for-service enrollees.
(Amends Welfare and Institutions Code §14132.36)

MEDICAL PRACTICE

AB 2013 (Irwin) – Generative artificial intelligence: training data transparency

Beginning Jan. 1, 2026, any developer of a generative AI system or service released on or after Jan. 1, 2022, and made publicly available to Californians, regardless whether the use of the system includes compensation, must publicly disclose documentation on the data used to train the AI. Documentation must also be disclosed before each substantial modification of such a system thereafter.
(Adds Civil Code Division 3, Part 4, Title 15.2 (commencing with §3110))

AB 3030 (Calderon) – Health care services: artificial intelligence

Requires a health facility, clinic, physician's office, or office of a group practice that uses generative artificial intelligence to generate written or verbal patient communications pertaining to patient clinical information to ensure that those communications include both (1) a disclaimer that indicates to the patient that a communication was generated by generative artificial intelligence and (2) clear instructions describing how a patient may contact a human health care provider. Disclosure is not required for patient communications read and reviewed by a human licensed health care provider, or for communications pertaining to non-clinical or administrative matters, such as appointment scheduling, billing, or other clerical or business matters.
(Adds Health and Safety Code Chapter 2.13, Division 2, (commencing with §1157))

SB 1061 (Limón) – Consumer debt: medical debt

Prohibits a person (including an individual or entity) from furnishing information about a medical debt to a consumer credit reporting agency, and makes such medical debt void and unenforceable if a person knowingly violates this provision. Requires a contract creating medical debt entered into on or after July 1, 2025 to include these requires. Defines medical debt to mean a debt owed by a consumer to a person whose primary business is providing medical services, products, or devices (excluding cosmetic surgery); medical debt includes but is not limited to medical bills that are not past due, or that have been paid. A violation of this law by person holding a license or permit issued by the state will be deemed a violation of the law governing that license or permit.
Prohibits a consumer credit reporting agency or an investigative consumer reporting agency from making a consumer credit report or an investigative consumer report containing information about medical debt. Prohibits a person who uses a consumer credit report in connection with a credit transaction from using medical debt listed on the report as a negative factor when making a credit decision. Requires a hospital to maintain all records relating to money owed to the hospital by a patient or their guarantor. Any contract entered into by a hospital related to the assignment or sale of medical debt must require the assignee or buyer and any subsequent assignee or buyer to maintain records related to litigation for 5 years.
(Amends Civil Code §§1785.3, 1785.13, 1786.18, and 1788.14; adds Civil Code §§1785.20.6 and 1785.27; amends Health and Safety Code §§1371.56, 1371.9, 1797.233, and 127425; amends Insurance Code §§10112.8 and 10126.66; adds Insurance Code §10112.75)

MENTAL HEALTH

SB 1184 (Eggman) – Mental health: involuntary treatment: antipsychotic medication

Authorizes a person's treating physician to request a hearing for a new determination of a person's capacity to refuse treatment with antipsychotic medication at any time in the 48 hours prior to the end of the duration of the current detention period when it reasonably appears to the treating physician that it is necessary for the person to be detained for a subsequent detention period and their capacity has not been restored. Under exigent circumstances, requires a hearing to determine a person's capacity to refuse treatment to be held as soon as reasonably practicable and within 24 hours.
(Amends Welfare and Institutions Code §§5325.2, 5332, 5334, 5336, and 5402)

SB 1238 (Eggman) – Health facilities

Expands the definition of "psychiatric health facility" for purposes of involuntary holds under the Lanterman-Petris-Short Act to also include a facility that provides 24-hour inpatient care for people with severe substance use disorders, or cooccurring mental health and substance use disorder; and expands the services such a facility may provide to include substance use disorder services.
(Amends Health and Safety Code §§1250.2 and 1275.1; amend Welfare and Institutions Code §§4080, 5008, 5404, and 5675; adds Welfare and Institutions Code §§4080.5, 5400.1, and 5675.05)

SB 1320 (Wahab) – Mental health and substance use disorder treatment

Requires a plan or insurer to establish a process to reimburse providers for mental health and substance use disorder treatment services that are integrated with primary care services, for plans issued, amended, or renewed on or after July 1, 2025.
(Adds Health and Safety Code §1374.725; adds Insurance Code §10144.58)

PEER REVIEW

AB 2225 (Rodriguez) – Discovery: prehospital emergency medical care person or personnel review committees
Extends the existing exemption from discovery in civil proceedings to include the proceedings and records of prehospital emergency medical care personnel committees and review committees focused on evaluating and improving care quality.
(Amends Evidence Code §1157)

PROFESSIONAL LICENSING AND DISCIPLINE

AB 1991 (Bonta) – Licensee and registrant renewal: National Provider Identifier
Requires a healing arts board to require a licensee or registrant who electronically renews their license or registration to provide to that board the licensee's or registrant's individual National Provider Identifier, if they have one.
(Adds Business and Professions Code §850.2)

AB 2164 (Berman) – Physicians and surgeons: licensure requirements: disclosure
Prohibits the Medical Board from requiring an applicant for a physician's and surgeon's license or a physician's and surgeon's postgraduate training license, or a renewing licensee, to disclose information regarding a condition or disorder that does not impair the applicant's ability to practice medicine safely.
(Amends Business and Professions Code §2425; adds Business and Professions Code §2090)

AB 2613 (Zbur) – Jacqueline Marie Zbur Rare Disease Advisory Council
Establishes within the California Health and Human Services Agency, until Jan. 1, 2029, the Jacqueline Marie Zbur Rare Disease Advisory Council appointed by the State Public Health Officer, to act as the advisory body on rare diseases to the Legislature, state, and private entities that provide services to, or that are charged with the care of, persons with rare diseases.
(Adds and Repeals Health and Safety Code Part 4.6, Division 106 (commencing with §124965))

AB 2860 (Garcia) – Licensed Physicians and Dentists from Mexico programs
Recasts the Licensed Physicians and Dentists from Mexico Pilot Program as two separate programs, one for physicians and one for dentists. Gradually raises the program cap for physicians from 155 active participants beginning in 2025, to 275 participants beginning 2041. Adds psychiatry as an eligible practice area beginning in 2025. Revises program participation requirements, including: replacing mandatory English class requirement with English proficiency tests; eliminating 6-month externship requirement; eliminating a minimum required length for the orientation program; and adding a new requirement for electronic medical records training for physicians.
(Adds Business and Professions Code Article 2.7, Chapter 4, Division 2 (commencing with §1645.4); adds Business and Professions Code Art. 6, Ch. 5, Div. 2 (commencing with §2125); repeals Business and Professions Code §124965)

AB 2864 (Garcia) – Licensed Physicians and Dentists from Mexico Pilot Program: extension of licenses
Requires the Medical Board, upon the request of an eligible licensee and the chief executive officer of the community health clinic that employs the licensee, to extend the license of a physician from Mexico issued pursuant the provisions described above for 3 years, with the extension period starting when the license expires. Request must have been submitted between Sep. 14, 2024 and Dec. 31, 2024. Urgency bill effective Sep. 14, 2024; sunsets Jan. 1, 2025.
(Adds and Repeals Business and Professions Code §853.1)

SB 639 (Limón) – Medical professionals: course requirements
Updates continuing education requirements for general internists and family physicians who have a patient population of which over 25% are 65 years of age or older to include training on the special care needs of patients with dementia as part of the 20% of all mandatory continuing education hours in a course related to geriatric medicine or the care of older patients.
(Amends Business and Professions Code §§2190.3 and 2811.5; adds Business and Professions Code §3524.6)

PUBLIC HEALTH AND HEALTH EQUITY

AB 1524 (Lowenthal) – Postsecondary education: on-campus access to drug testing devices
Requires the California State University and community college districts to stock drug testing devices, available and accessible, free-of-charge, in the health center located on each campus and post a notice on these requirements in a prominent and conspicuous location.
(Adds Education Code §66027.3)

AB 1810 (Bryan) – Incarcerated persons: menstrual products
Requires an incarcerated person who menstruates or experiences uterine or vaginal bleeding to have ready access to menstrual products without having to request them.
(Amends Penal Code §3409 and 4023.5; amends Welfare and Institutions Code §221)

AB 1841 (Weber) – Student safety: opioid overdose reversal medication: student housing facilities
Requires the governing board of each community college district and the Trustees of the California State University to send an email at the beginning of each academic semester or term notifying students of the presence and location of opioid overdose reversal medication, and that each residential advisor and house manager has received opioid overdose prevention and treatment training. Requires each residential advisor and house manager to receive opioid overdose prevention and treatment training. Requires each campus health center located on a campus to distribute 2 doses of federally approved opioid overdose reversal medication to each college- or university-affiliated fraternity or

sorority facility at the beginning of each academic semester or term, to be maintained by the housing facility in an accessible location. Prohibits disciplinary measures from being imposed for any violation of the institution's student conduct policy regarding drug possession, use, or treatment that occurs at or near the time of an incident where a residential advisor, resident, or house manager administers a dose of approved opioid overdose reversal medication.
(Amends Education Code §67384; adds Education Code §67384.5)

AB 1996 (Alanis) – Opioid antagonists: stadiums, concert venues, and amusement parks: overdose training
Requires each stadium, concert venue, and amusement park to ensure that the naloxone hydrochloride or other opioid antagonist is easily accessible, and its location is known by emergency responders on the premises or otherwise widely known.
(Amends Health and Safety Code §11871)

AB 2300 (Wilson) – Medical devices: Di-(2-ethylhexyl) phthalate (DEHP)
Beginning Jan. 1, 2030, prohibits a person or entity from manufacturing, selling, or distributing into commerce in the State of California certain intravenous (IV) solution containers made with intentionally added DEHP; provides a 2-year extension for a person or entity who has a pending U.S. Food and Drug Administration (FDA) approval or who lacks adequate equipment to manufacture DEHP-free IV solution container and meets other requirements, including providing prescribed notices to consumers. Beginning Jan. 1, 2035, prohibits a person or entity from manufacturing, selling, or distributing into commerce in the State of California certain IV tubing made with intentionally added DEHP.
(Adds Health and Safety Code Ch. 18 Part 3, Division 104 (commencing with §109050))

AB 2527 (Bauer-Kahan) – Incarceration: pregnant persons
Requires incarcerated pregnant persons in the state prison to be provided with free and clean bottled water and daily high-quality and high caloric nutritional meals. Prohibits incarcerated pregnant persons in the state prison from being placed in solitary confinement or restrictive housing units during their pregnancy, if known to be pregnant, or for 12 weeks postpartum.
(Amends Penal Code §3408)

AB 2871 (Maienschein) – Overdose fatality review teams
Authorizes a county or regional group of counties to establish an interagency overdose fatality review team, comprised of experts in the field of forensic pathology, coroners and medical examiners, county, local, state, and federal law enforcement, and public health staff, to assist local agencies in identifying and reviewing overdose fatalities, facilitate communication among the various persons and agencies involved in overdose fatalities, and integrate local overdose prevention efforts through strategic planning, data dissemination, and community collaboration.
(Adds Health and Safety Code Division 10.1 (commencing with §11675))

AB 2907 (Zbur) – Firearms: restrained persons
Enacts firearm restriction and relinquishment procedures for individuals subject to criminal protective orders in domestic violence cases, requires arresting officers to inquire about firearms ownership during domestic violence arrests, and mandates that officers document and report any firearms found to the prosecutor.
(Amends Penal Code §§136.2, 273.5, 273.75, 368, 646.9, 1203.097, and 29825; adds Penal Code §§273.76 and 29825.5)

AB 2998 (McKinnor) – Opioid overdose reversal medications: pupil administration
Prohibits a school district, county office of education, or charter school from prohibiting a pupil 12 years of age or older, while on a school site or participating in school activities, from carrying or administering, for the purposes of providing emergency treatment to persons who are suffering, or reasonably believed to be suffering, from an opioid overdose, a naloxone hydrochloride nasal spray or any other opioid overdose reversal medication that is federally approved for over-the-counter, nonprescription use.
(Adds Education Code §49414.35)

AB 3218 (Wood) – Unflavored Tobacco List
Requires the Attorney General to establish and maintain on the Attorney General's website a list of tobacco product brand styles that lack a characterizing flavor by Dec. 31, 2025. Bans the sale of any tobacco product not on the Attorney General's Unflavored Tobacco List.
(Amends Business and Professions Code §§22980 and 22990; adds Business and Professions Code §§22974.2 and 22978.3; Amends Health and Safety Code §104559.5; adds Health and Safety Code Article 4.5, Ch. 1, Part 3, Division 103 (commencing with §104559.1); amends Revenue and Taxation Code 30101.7)

SB 1248 (Hurtado) – Pupil health: extreme weather conditions: physical activity
Requires the State Department of Education, on or before Jan. 1, 2026, and in consultation with relevant stakeholders and experts, to compile and post on the department's website standardized guidelines specifying temperature thresholds or index ratings that trigger modifications to pupil physical activities during extreme weather conditions. Requires those standardized guidelines to consider relevant factors, including pupil ages, harmful duration of exposure to extreme weather conditions, overall pupil safety, and available mitigation measures. Requires school districts, county offices of education, and charter schools, on or before July 1, 2026, to develop, adopt, and implement weather protocols for extreme weather conditions consistent with the department guidelines, and to annually review and update the weather protocols as needed.
(Adds Education Code §33355)

RECORDKEEPING

AB 3221 (Pellerin) – Department of Managed Health Care: review of records
Requires health care service plans, including any provider or subcontractor providing health care of other services to a plan, to provide their records, books, and papers to the Department of Managed Health Care (DMHC) in electronic form, when available. Requires electronic records to be digitally searchable to the greatest extent feasible.
(Amends Health and Safety Code §§1380, 1381, and 1386)

REIMBURSEMENT

AB 2297 (Friedman) – Hospital and Emergency Physician Fair Pricing Policies
Authorizes an emergency physician to choose to grant eligibility for a discount payment policy to patients with incomes over 400% of the federal poverty level. Clarifies that out-of-pocket costs for "high medical costs" means any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing. Requires a hospital's charity care or discount payment policy to clearly state eligibility criteria based on income consistent with application of the federal poverty level. Prohibits a hospital from considering a patient's monetary assets in determining eligibility for charity care or discount payment policies, but authorizes a hospital to consider availability of a patient's health savings account.
(Amends Health and Safety Code §§127400, 127401, 127405, 127425, 127435, 127436, 127440, 127450, 127452, and 1274551367.002; adds Health and Safety Code §127400.5)

AB 2703 (Aguiar-Curry) – Federally qualified health centers (FQHCs) and rural health clinics (RHCs): psychological associates
Adds licensed psychological associate and professional clinical counselor to the list of eligible practitioners for which FQHCs and RHCs may bill for patient encounters.
(Amends Welfare and Institutions Code §14132.100)

AB 3275 (Soria) – Health care coverage: claim reimbursement
Beginning Jan. 1, 2026, requires health care service plans and health insurers, including Medi-Cal managed care plans, to reimburse complete claims within 30 calendar days or notify claimants of contested or denied claims within the same timeframe. Requires a complaint made by an enrollee about a delay or denial of a payment of a claim to be treated as a grievance, regardless of whether the enrollee uses the term "grievance." Provides DMHC and the Department of Insurance an exemption from the Administrative Procedure Act to issue implementing guidance and amend existing regulations for consistency.
(Amends, repeals, and adds Health and Safety Code §§1371 and 1371.35; adds Health and Safety Code §1371.34; amends, repeals, and adds Insurance Code §§10123.13 and 10123.147; adds Welfare and Institutions Code §14093.08)

SB 1180 (Ashby) – Health care coverage: emergency medical services
Requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2025, to establish a process to reimburse for services provided by a community paramedicine program, a triage to alternate destination program, and a mobile integrated health program.
(Adds Health and Safety Code §1371.51; adds Insurance Code §10126.61; adds Welfare and Institutions Code §14132.13)

REPORTING REQUIREMENTS

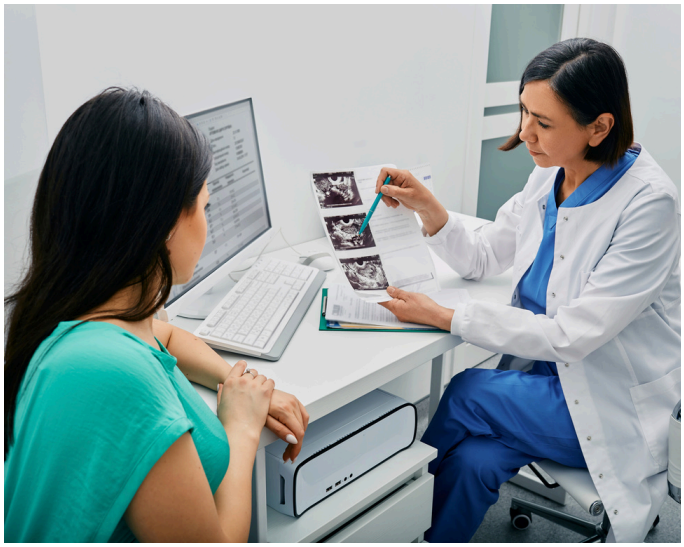
AB 1859 (Alanis) – Coroners: duties
Authorizes a coroner to test the bodily fluid of a deceased person for the presence of xylazine if the coroner reasonably suspects the person died from an accidental or intentional opioid overdose or if the person was administered an overdose intervention drug prior to death and was unresponsive to the drug.
Requires the coroner to report a positive result to the Overdose Detection Mapping Application Program and provide CDPH with a quarterly report on positive results.
Requires the department to post specified information regarding the number of xylazine-positive results it receives on the California Overdose Surveillance Dashboard on the department's website.
(Adds Government Code §27523)

AB 2080 (Arambula) – University of California: schools of medicine: report
Requests the University of California to publish on its website on or before Dec. 1, 2026, and each Dec. 1 thereafter until 2035, a report containing data on students enrolled in a University of California school of medicine, including the number of first-generation students and the number of federal Pell Grant recipients enrolled.
(Adds and Repeals Education Code §66207.5)

SB 957 (Wiener) – Data collection: sexual orientation, gender identity, and intersex status
Requires CDPH to collect voluntarily provided self-identification info about sexual orientation, gender identity, and variations in sex characteristics/intersex status (SOGISC) from third parties, including but not limited to local health jurisdictions, on any forms or electronic data systems, unless prohibited by law; collection of this data is not required for individuals under 18 years of age. Adds an adult patient's voluntary self-identified SOGISC and sex assigned at birth to list of data that providers, schools, and other agencies must disclose to local and state health department immunization registries; prohibits a provider from disclosing that information for a patient or client who is under 18 years of age.
(Amends Government Code §8310.8; Amends Health and Safety Code §120440; Adds Health and Safety Code Division 12 (commencing with §152000))

SB 1099 (Nguyen) – Newborn screening: genetic diseases: blood samples collected
Requires CDPH, commencing July 1, 2026, and each July 1 thereafter until the department has provided 5 annual reports, to publish a report providing data regarding the number of research projects utilizing residual screening samples from the program and the number of inheritable conditions identified by the original screening tests during the previous year calendar.
(Amends Health and Safety Code §§124977 and 124991; adds Health and Safety Article 2.5, Chapter 1, Part 5, Division 2 (commencing with §125010))

SB 1333 (Eggman) – Communicable diseases: HIV reporting
Requires employees and contractors to annually sign the confidentiality agreements prior to accessing confidential HIV-related public health records agreement and repeals the annual review of the agreement. Expands and simplifies authority of CDPH to disclose personally identifiable information in HIV-related public health records with federal agencies and collaborating researchers when necessary for specified purposes, including to coordinate, link, or reengage care; removes requirement for written authorization from the subject or their guardian if disclosure meets specified necessity criteria.
(Adds Health and Safety Code §§121022 and 121025)



REPRODUCTIVE HEALTH

AB 1936 (Cervantes) – Maternal mental health screenings

Requires the maternal mental health program to consist of at least one maternal mental health screening during pregnancy, at least one additional screening during the first 6 weeks of the postpartum period, and additional postpartum screenings, if determined medically necessary and clinically appropriate in the judgment of the treating provider.
(Amends Health and Safety Code §1367.625; amends Insurance Code §10123.867)

AB 2085 (Bauer-Kahan) – Planning and zoning: permitted use: community clinic

Streamlines the approval process for community clinics providing reproductive health services by making them a permitted use in certain zones, exempting them from California Environmental Quality Act (CEQA) review, and requiring local agencies to approve or deny the application within 60 days subject to specified requirements.
(Adds Government Code Ch. 4.2.5 Title 7, Division 1 (commencing with §65914.900))

AB 2099 (Bauer-Kahan) – Crimes: reproductive health services

Enhances penalties for crimes related to the harassment or intimidation of reproductive health care patients, providers, or assistants by making the following violations punishable as either misdemeanors or felonies: doxing a reproductive health care services patient, provider, assistant, or other individuals residing at the same home address, if bodily injury occurs; impeding access to reproductive health services facilities through use of force, threat of force, or physician obstruction or otherwise violating the California Freedom of Access to Clinic and Church Entrances Act; or committing a hate crime involving force or threats of force.
(Amends Government Code §6218.01; amends Penal Code §§422.6 and 423.3)

AB 2129 (Petrie-Norris) – Immediate postpartum contraception

Requires a contract between a health care service plan or health insurer and a health care provider issued, amended, or renewed on or after Jan. 1, 2025, to authorize a provider to separately bill for devices, implants, and professional services, associated with immediate postpartum contraception if the birth takes place in a general acute care hospital or licensed birth center. Prohibits a provider contract from considering those devices, implants, or services to be part of a payment for a general obstetric procedure.
(Adds Health and Safety Code §1367.627; adds Insurance Code §10123.869)

AB 2319 (Wilson) – California Dignity in Pregnancy and Childbirth Act

Requires an implicit bias program to include recognition of intersecting identities and the potential associated biases, and extends implicit bias training requirements for health care providers involved in perinatal care to include all providers who are regularly assigned to provide perinatal care, as defined, including but not limited to those in primary care clinics,

alternative birthing centers, outpatient clinics, or emergency departments; as well as to all persons who are regularly assigned to positions where they interact with perinatal patients, including those who facilitate, control, or coordinate access to timely and appropriate medical treatment, and any others who provide medical or ancillary treatment. Adds prenatal care to the definition of perinatal care for this purpose.
Requires a health care provider subject to this requirement to complete initial basic training on implicit bias based on the revised components by June 1, 2025 for current health care providers, and within 6 months of the start date for new hires. Requires facilities, by February 1 of each year starting in 2026, to provide proof of compliance and report certain data to the Attorney General regarding compliance rates for all providers who are subject to the training requirement. Authorizes the Attorney General to assess penalties for noncompliance.
(Amends Health and Safety Code §§123630.1, 123630.2, and 123630; adds Health and Safety Code §§123630.6 and 123630.7)

AB 2740 (Waldron) – Incarcerated persons: prenatal and postpartum care
Requires, within 7 days of arriving at a prison, each incarcerated pregnant person to be referred to a social worker to discuss parenting and newborn care classes, as well as options for newborn placement and visitation. Requires a prenatal care plan to include additional meals and beverages. Requires the mother and newborn to remain at a medical facility post-delivery for as long as the medical provider determines is necessary for recovery and postpartum care. Requires the mother and child to be provided with bonding time as specified. Requires the incarcerated mother to be permitted to breastfeed the newborn at the medical facility, and pump breast milk to be stored and provided to the child. Requires the Department of Corrections and Rehabilitation to expedite a family visitation application process to prevent delays for visitation for the incarcerated mother and newborn child following delivery.
(Adds Penal Code §§3408.4, 3408.5, and 6404.5)

SB 729 (Menjivar) – Health care coverage: treatment for infertility and fertility services
Requires large group health care service plan contracts and disability insurance policies issued, amended, or renewed on or after July 1, 2025, to provide coverage for the diagnosis and treatment of infertility and fertility services, including a maximum of 3 completed oocyte retrievals with unlimited embryo transfers in accordance American Society for Reproductive Medicine (ASRM) guidelines. Requires small group health plans and insurance policies to offer coverage for the diagnosis and treatment of infertility and fertility services. Revises the definition of infertility, and removes the exclusion of in vitro fertilization from coverage. Prohibits specified exclusions and coverage limitations, or the imposition of cost sharing or coverage terms on infertility benefits that are different from those imposed on benefits for services not related to infertility.
(Adds and repeals Health and Safety Code §1374.55; adds and repeals Insurance Code §10119.6)

WORKFORCE AND OFFICE SAFETY ISSUES

AB 977 (Rodriguez) – Emergency departments: assault and battery
Enhances criminal penalties for an assault or battery committed against a physician, nurse, or other health care worker of a hospital engaged in providing services within the emergency department, making such crimes punishable by imprisonment in a county jail not exceeding one

year, by a fine not exceeding $2,000, or by both that fine and imprisonment. Authorizes a health facility that maintains and operates an emergency department to post a notice in the emergency department stating that an assault or battery against staff is a crime, and may result in a criminal conviction.
(Adds Health and Safety Code §1317.5a; amends Penal Code §§241 and 243)

AB 1976 (Haney) – Occupational safety and health standards: first aid materials: opioid antagonists
Requires the Division of Occupational Safety and Health (Cal. OSHA), before Dec. 1, 2027, to submit a draft rulemaking proposal to revise specified regulations on first aid materials and emergency medical services to require first aid materials in a workplace to include naloxone hydrochloride or another opioid antagonist approved by the FDA to reverse opioid overdose and instructions for using the opioid antagonist. Requires the division's regulations to provide guidance to employers on proper storage. Also requires the Occupational Safety and Health Standards Board to consider adopting revised standards relating to the above by Dec. 1, 2028. Reiterates existing law protecting from civil liability an individual who administers naloxone hydrochloride or another FDA-approved opioid antagonist in a suspected opioid overdose emergency.
(Adds Labor Code §6723)

AB 2357 (Bains) – University of California: school of medicine: University of California Kern County Medical Education Endowment Fund
Establishes the University of California Kern County Medical Education Endowment Fund, upon appropriation by the Legislature, to support the development, operation, and maintenance of a UC School of Medicine branch campus in Kern County.
(Adds Education Code Ch. 2 Part 57, Division 9, Title 3 Article 6.6 (commencing with §92168).)

SB 828 (Durazo) – Minimum wages: health care workers: delay
Delays the health care worker minimum wage requirements established by SB 525 (2023) by one month, extending the minimum wage increase effective dates from June 1 to July 1 for all applicable years for specified health care workers working at any covered health care facility employer, as defined.
(Amends Labor Code §§1182.14 and 1182.15)

SB 159 (Committee on Budget and Fiscal Review) – Health
Further delayed the initial effective date of July 1, 2024 for the health care worker minimum wage requirements established by SB 525 (2023) and SB 828 (2024), delaying the effective date of the first health care minimum wage increase contingent on triggers based on either state revenues or notification by DHCS to the Legislature that it has initiated the data retrieval related to hospital quality assurance fees. The first health care worker minimum wage increase became effective on Oct. 16, 2024, following notification by DHCS that it had initiated data retrieval on Oct. 1, 2024.
(Amends Labor Code §§1182.14 and 1182.15; adds Labor Code §1182.16)

SB 909 (Umberg) – Steven M. Thompson Physician Corps Loan Repayment Program
Eliminates the $105,000 maximum limit for loan repayments per eligible licensed physician. Adds psychiatry to the list of primary specialty areas. Decreases service obligation in a medically underserved area from 3 years to 2 years.

Authorizes the Department of Health Care Access and Information to create additional positions, not using funds from the Medically Underserved Account for Physicians, for specialties outside of the primary specialties.
(Amends Health and Safety Code §§128551, 128552, 128553, and 128555)

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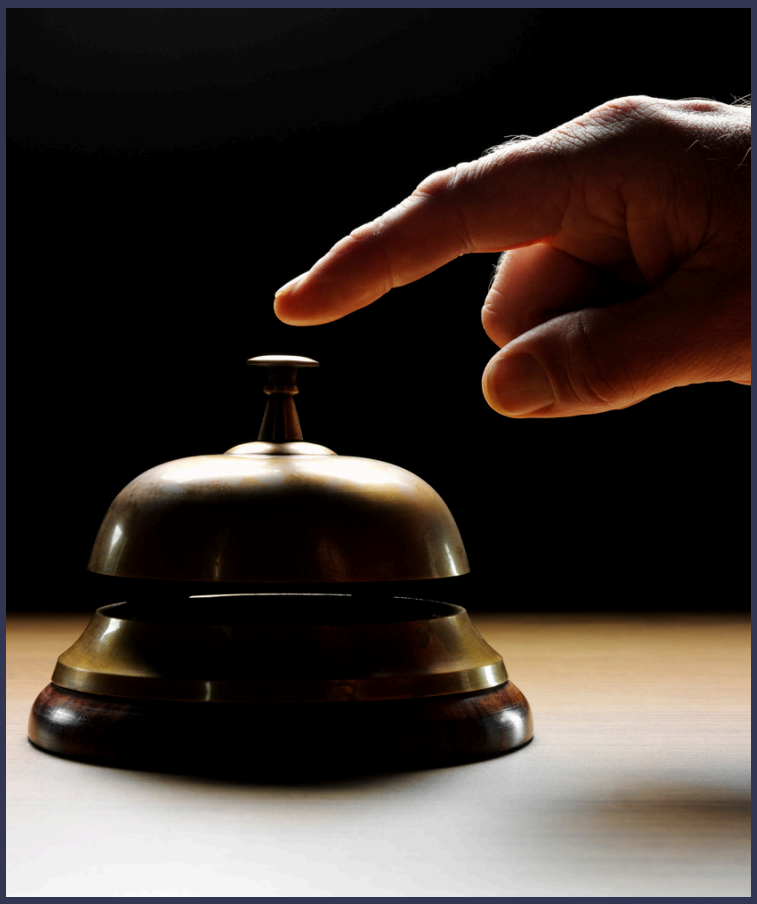
THE COST OF EXCLUSIVITY: CALIFORNIA PRIMARY CARE PHYSICIANS EMBRACE CONCIERGE CARE



The healthcare landscape in California is evolving as traditional fee-for-service models give way to concierge medicine and other specialized care practices. Concierge medicine, also known as boutique or retainer-based healthcare, offers patients enhanced access to physicians, personalized treatment, and an increased focus on preventive care in exchange for membership fees. These models minimize the role of third-party payers, allowing physicians to dedicate more time to each patient and deliver care tailored to individual needs. As concierge practices expand across California, they could offer a more patient-centered approach, emphasizing accessibility, continuity, and strengthened physician-patient relationships – at least to those who can afford the membership fees. This article will examine the various models of concierge practices, the legal considerations arising from them, and the broader implications for California's healthcare system as it shifts away from traditional delivery methods.

I. OVERVIEW OF TRADITIONAL FEE FOR SERVICE PRACTICES

Traditional primary care settings have generally been organized as small solo or group practices, often consisting of no more than five physicians. Historically, these primary care practices have operated under a fee-for-service ("FFS") payment model wherein medical providers are compensated for each service rendered. Under the FFS model, primary care providers generally enroll in Medicare, allowing them to receive direct reimbursements from the Centers for Medicare & Medicaid Services ("CMS") for services provided to Medicare beneficiaries based on standardized rates determined by CMS. Additionally, FFS practices contract with private insurance companies and bill them directly for services rendered to covered patients. In theory, the FFS model allows primary care practices to establish consistent reimbursement streams from both private and public payers. However, the reality is more complex, as significant operational and financial challenges often counterbalance the advantages of this structure.

One of the most pressing issues in FFS primary care practices is the large patient load each provider must manage. On average, a primary care physician's patient panel consists of approximately 2,500 patients, leading to strained resources and limited accessibility. [1] National surveys have revealed a

concerning trend – the percentage of patients reporting difficulties in promptly accessing their primary care providers increased from 53% in 2006 to 57% in 2011. [2] Operational inefficiencies further complicate the traditional primary care landscape. Primary care physicians spend a substantial portion of their day—between 20% to 33%—on administrative tasks unrelated to direct patient care, such as charting and documentation for insurance reimbursement purposes. [3] Furthermore, rising costs associated with care delivery, combined with declining reimbursements, create a precarious financial environment that many practices struggle to navigate. [4] Finally, the increasing demand for primary care services is outpacing the current supply of providers. [5] These financial pressures have driven physicians to seek alternative models of care that offer better returns and more manageable workloads.

II. TRANSITION TO "CONCIERGE" MEDICINE AND HEALTHCARE SERVICES

Concierge medicine, also known as boutique or retainer medicine, refers to a healthcare model where patients pay an upfront membership fee in exchange for premium healthcare services and enhanced access to such services. The membership fee, typically paid in annual, quarterly, or monthly installments, ranges from a few hundred to several thousand dollars annually. In return, patients have access to same-day appointments, 24/7 direct access to their physician through phone or digital communications, extended office visits, house calls, advanced imaging, supplements, nutrition and health coaching, and a more personalized approach to care. [6] The U.S. concierge and personalized medical services market is projected to exceed $11 billion annually by 2032. [7]

As discussed above, physicians practicing in traditional FFS primary care settings often manage large patient panels, leading to shorter appointments, long waiting periods, and limited opportunities for preventative care discussions. [8] In contrast, concierge physicians limit their patients significantly, typically servicing only several hundred patients. [9] Concierge physicians have control over the number of patients they treat and the length of time spent with each patient. These factors enable physicians to spend more time with each patient, arguably enhancing patient satisfaction and health outcomes. In need of quality care and work-life balance, patients and physicians alike have increasingly transitioned to concierge models of care.

This pay-to-play concierge medicine model has expanded beyond primary care practices to include other healthcare and wellness services. Companies like Hims & Hers have made high-end weight loss and metabolic health programs easily accessible to individuals seeking specialized and personalized weight management (in addition to other) services. Concierge psychiatry and psychology practices have grown significantly, providing expedited access to mental health care with tailored treatment plans and enhanced support. Furthermore, clinics specializing in hormone treatments and sexual health have embraced the concierge style of practice, offering personalized fertility and maternity care. These programs, like Kindbody and JOI, often include comprehensive wellness plans, birth control counseling, hormone counseling, and replacement therapy, catering to individuals seeking a higher level of individualized care. Like some concierge medical models, these ancillary concierge service practices operate wholly outside of the insurance system and offer specialized services to those willing to pay.

III. CONCIERGE MEDICAL PRACTICE MODELS

The concierge movement has seemingly had the heaviest impact on primary care practices. There are two primary membership models that primary care practices generally adopt: (1) hybrid and (2) direct primary care ("DPC").

A. Hybrid Concierge Practices

In hybrid concierge models, medical practices charge patients a membership fee in addition to billing their insurance, including Medicare, for traditional medical services. The membership fee typically covers enhanced services, such as 24/7 access and more extended visits, that insurance companies do not reimburse. Practices that have deployed a hybrid model aim to appeal to a broader demographic by offering concierge services without entirely abandoning the insurance framework. Membership fees for these practices are often significantly lower than those of DPC and high-end models because insurance companies reimburse hybrid physicians for their professional services.

Hybrid concierge practices are frequently organized as "friendly-PC" models to work around California's prohibition of the corporate practice of medicine ("CPOM"), which prevents non-physicians from owning or controlling medical practices. [10] The friendly-PC model enables management service organizations ("MSOs") or other non-physician entities to form business relationships with physicians while remaining compliant with California's CPOM prohibition.

In this model, a professional corporation ("PC"), owned and controlled by a licensed physician (the friendly physician), contracts with an MSO via a management services agreement ("MSA"). Lay persons often have a majority ownership interest in the MSO, which are generally organized as limited liability companies. The friendly physician may have a minority ownership interest in the parties' MSO, depending on the business relationship. The MSO provides the PC all non-clinical and administrative services for a management fee. The friendly physician, PC, and MSO also enter into a Succession Agreement, which gives the MSO the right to remove the friendly physician as the PC's sole owner, potentially enabling the MSO to indirectly control the PC's operations.

Perhaps the best-known hybrid concierge practice that operates under a friendly PC structure is One Medical. One Medical patients pay a $199 annual fee (reduced to $99 for Amazon Prime Members), which gives them access to "time-saving services through the One Medical Mobile App offered by 1Life [Healthcare], including online appointment booking, online prescription renewal requests, on-demand video visit technology, and digital access to virtual medical services on the go." [11][12] 1Life Healthcare operates as One Medical's MSO and provides the 'premium' and 'enhanced' administrative components of One Medical's practice. On the clinical side, One Medical operates various PCs owned (directly or indirectly via a parent entity) by Andrew Diamond, M.D., the friendly physician. One Medical and other friendly PC arrangements must ensure the MSO does not exert undue influence over the PC's clinical decisions to avoid enforcement actions under California's CPOM prohibition.

Because One Medical treats Medicare beneficiaries (as most hybrid models do), its membership fee cannot include healthcare services reimbursable by Medicare. Medicare providers cannot charge Medicare beneficiaries extra for Medicare-covered services. [13] One Medical seemingly navigates Medicare's extra charge restrictions, stating its fee only covers extraneous services, such as "innovative digital health tools and value-added services that make One Medical unique," and "high-touch and value-added non-medical services including lifestyle and wellness offerings and value-added personal assistance services." [14][15]

Hybrid models also risk incurring breach of contract claims from third-party payers. Payer contracts often prohibit contracted providers from charging the payers' beneficiaries for services covered by the health plan. Some payer contracts go one step further and prohibit contracted providers from discriminating in treating the providers' patients based on the patient's payment source.

Furthermore, some health plans' provider manuals, which are incorporated into their provider contracts, prohibit physicians from charging patients a concierge membership fee. California's Blue Shield Independent Physician and Provider Manual incorporates a blanket prohibition and directs its contracted physicians to "abstain from assessing against members any concierge, boutique or membership fees, or any fees that qualify as surcharges as defined in the Health and Safety Code." [16]

It appears that multiple payers are forming concierge practices to compete with One Medical, Forward, etc., and as such, want to limit their contracted providers from competing with their business endeavors. For example, in 2022, Cigna started its concierge program, Pathwell. These trends indicate that payers might be clamping down on concierge practices and enforcing the terms of their payer agreements.

B. Direct Primary Care Practices

The safest way for a physician to practice concierge medicine is not to contract with any payers and opt out of Medicare. To opt out of Medicare and bill Medicare beneficiaries for covered services, enrolled providers must submit an Opt-Out Affidavit to the provider's Medicare Administrative Contractor. This process could take several months, depending on when the provider's Medicare Op-Out Affidavit is filed. This approach is often called the direct primary care or DPC model. The DPC model offers a simpler approach, where patients pay a flat monthly or annual fee directly to the physician. This fee covers all routine care, such as office visits, preventive care, and basic lab work. DPC fees range from $10,000 to $40,000 annually. Private Medical, a DPC practice that caters to the most affluent patients, charges a base $40,000 annual membership fee, which covers:

- An in-house team to manage the member's entire health portfolio
- Facilitating expedited appointments with specialists
- Personalized, TSA-approved travel kits and worldwide medical evacuation jet services for crises

- Custom genetic analysis
- Diamond lab panel
- 50-page personal health report
- Unlimited direct access to the patient's physician
- Unlimited specialized testing and imaging
- Biometric tracking device

DPC practices do not bill insurance, offering patients and providers more straightforward financial arrangements. Nonetheless, DPC patients must maintain independent health insurance to cover their medical care provided outside of the practice, such as hospitalization or specialty consults. Patients will also be responsible for all cost-sharing obligations for services not included in the DPC practice's membership fee. Arguably, DPC practices can save on overhead costs by eliminating the need for billing specialists/programs and can avoid hassles from third-party insurers. Eliminating third-party insurers should give these physicians more autonomy in their patients' care.

DPC practices must exercise caution not to violate California's Knox-Keene Health Care Services Plan Act of 1975. DPC practices risk being classified as a health care service plan, which, per the Knox-Keene Act, must obtain a license from California's Department of Managed Care. [17] Healthcare service plans provide or arrange health services to subscribers or enrollees in exchange for a pre-paid or periodic charge. [18] These health plans assume full financial responsibility for providing all or a substantial portion of a patient's health care, including primary, specialist, and hospital services. [19]

If a DPC practice like Private Medical assumes full financial responsibility for its members' health care needs and offers services beyond primary care, it would operate like an HMO. As such, the Knox-Keene Act could require the practice to obtain a health plan license. To avoid this classification, DPCs should limit their services to primary care and avoid bundling other types of care (like specialist or hospital services) into their membership fees.

IV. Legal Issues and Limitations of the Concierge Model

While concierge services are legal, they pose unique challenges to established healthcare laws, including the Stark Law, Anti-Kickback Statute ("AKS"), and Medicare regulations. These challenges are significant as they risk violating the core principles of patient equity and access in healthcare.

A. Medicare and Medicaid Compliance

Federal law prohibits Medicare providers from charging membership fees for access to services covered by Medicare. This creates a conflict for providers such as One Medical, which wishes to cater to a broader patient base while remaining compliant with Medicare regulations. One Medical, for example, accepts insurance but must remain cautious in defining membership fees to avoid appearing as "upcharging" for Medicare-covered services. Violations can result in fines and possible exclusion from Medicare participation, which could significantly impact revenue and service scope.

B. Anti-Kickback and Self-Referral Regulations

The AKS and the Stark Law restrict financial relationships that could lead to the overutilization of healthcare services and the risk of unnecessary or excessive treatments. In concierge medicine, providers might be incentivized to refer patients for services that can be monetized through additional, fee-based programs within the clinic. For example, a concierge provider could indirectly encourage patients to undergo preventive testing or wellness services at affiliated facilities, raising potential AKS or Stark Law concerns. Navigating these regulations requires a careful balance between offering enhanced care and avoiding practices that might be viewed as self-referrals or kickbacks.

C. Privacy Concerns

The concierge model strongly emphasizes convenience, often leveraging digital platforms to connect patients and providers. One Medical, for instance, uses mobile apps to streamline appointments, records, and communication. This heightened reliance on technology increases the risk of HIPAA breaches. Handling patient data securely while offering high-tech convenience requires substantial investment in cybersecurity measures and strict adherence to HIPAA compliance protocols. Additionally, using digital records and third-party integrations raises the potential for unauthorized access, putting patient privacy at risk.

The concierge model poses legal concerns and practical and ethical limitations. While concierge medicine seeks to optimize patient care, it also presents systemic challenges to broader healthcare access.

D. Equity and Access to Care

The exclusivity of the concierge model is perhaps its most controversial aspect. An NPR poll reported that, as of 2020, more than one in five wealthy people already participate in concierge medicine. [20] The rates for low and middle-income people are less than half that. [21] By prioritizing patients who can afford the membership fee, the model inherently limits access to those from lower income brackets. This two-tiered system raises significant ethical questions about healthcare equity, as concierge models may perpetuate or exacerbate disparities. For instance, in communities with limited access to primary care physicians, a shift towards concierge services could further strain resources for individuals relying on traditional healthcare, creating a healthcare “gap” that is not only practical but also moral.

V. Impact of the Concierge Model

Concierge medicine has the potential to enhance efficiency in healthcare delivery. Introducing a pricing mechanism allows patient segmentation based on the value they assign to access, as demonstrated by their readiness to pay. This innovative approach could lead to better health outcomes, particularly if a patient's willingness to pay indicates a greater need for improved access due to the potential impact on their health. In such cases, allocating a provider’s time becomes more targeted, focusing on patients who would benefit most from increased care. For instance, enhanced access and more time with a physician might decrease the need for costly services like emergency room visits and hospitalizations.

On the other end of the spectrum, the influx of physicians into concierge practices may drain talent from traditional healthcare providers, impacting the quality of care available to the general public. Because concierge medicine offers physicians higher pay and lighter patient loads, it creates a strong incentive for primary care physicians to transition away from traditional roles. This "brain drain" effect could impact healthcare facilities in underserved communities, reducing access to skilled providers and increasing patient-to-physician ratios in public health systems.

Further, the concierge model is premised on generating predictable revenue from membership fees, leading to potential conflicts between profit and patient care. For example, concierge providers may feel pressured to focus on high-margin services or wellness programs that contribute to revenue but offer limited patient benefits. This profit-oriented approach could divert focus from basic primary care needs, such as chronic disease management, as providers prioritize more lucrative preventive or wellness services.

As the demand for concierge healthcare grows, regulatory and structural reforms will be essential to address the legal and ethical issues outlined above. Some potential solutions include:

1. Transparent Pricing Models: Ensuring that concierge practices delineate membership fees from charges for Medicare-covered services could reduce compliance risks. Transparent pricing models would also clarify the distinction between essential care and concierge enhancements, addressing patient confusion and regulatory scrutiny.

2. Prohibit Discriminatory Pricing in DPC Models: California does not seem to prohibit DPC physicians from charging higher prices to sicker or older patients than to healthier or younger ones. As a result, DPC providers may be inclined to adopt pricing models that vary based on their patients' ages or health status. To prevent this pricing discrimination, regulators could prohibit DPC practices from implementing pricing structures that charge higher rates for older patients and those with pre-existing conditions.

3. Broader Access Incentives: Expanding concierge care to include more subsidized membership tiers or partnering with public health programs could help reduce healthcare disparities. For instance, allowing low-income patients access to certain concierge benefits or introducing sliding-scale fees could bring equity to the model.

4. Collaborative Partnerships: Concierge providers could work alongside traditional healthcare systems to supplement, rather than replace, public health services. Partnerships with community health organizations or hospital networks could provide a model for integration, in which concierge services offer targeted support to healthcare deserts or underserved populations, thus addressing gaps rather than exacerbating them.

VI. Conclusion

Concierge healthcare models present promising opportunities and considerable challenges within the U.S. healthcare landscape. While they offer a much-needed response to some failings in traditional primary care—such as accessibility and patient satisfaction—they also create significant legal, ethical, and practical concerns. Proactive regulation, industry transparency, and innovative partnerships will be critical to ensure that the growth of concierge medicine aligns with the broader goals of equity and quality in healthcare. By addressing these limitations head-on, the concierge model may find a sustainable and equitable place within the American healthcare system.

Endnotes

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[21] Id.

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CRIMINALIZATION OF HEALTH CARE SERVICES SERIES:

California's Abortion Shield Laws in a Post-Dobbs Era

By Sofia Pedroza

I. Introduction

Since Dobbs v. Jackson Women's Health overturned Roe v. Wade and invalidated the federal Constitutional right to abortion, the national landscape of laws related to abortion care has become a patchwork of differing state laws and legal challenges. As of January 2025, 19 states are enforcing law that restrict abortion, resulting in an uncertain legal environment for patients and health care providers who may now face civil and criminal liability in other states. [1] California, on the other hand, invested over $200 million and enacted nearly thirty laws to protect and expand abortion access since the Dobbs decision. [2] This broad array of legal protections is sometimes referred to as "shield laws," especially when a state law purports to protect patients, providers, or others from penalties or liability imposed by other states.

This article provides a high-level survey of shield laws enacted in California from 2022-2024. These laws vary in scope, may apply to civil and criminal liability, and protects providers and patient privacy. While this article focuses on shield laws related to abortion, several statutes mentioned here also include protections for gender affirming care, contraception, and reproductive health care broadly. In assessing the extent of the protections afforded by these shield laws, it will be important to note the scope of health care services defined and protected and how they may overlap with federal law and the laws of other states.

II. The Right to Abortion in California

Since 2022, the California state constitution Article I § 1.1 provides that the state shall not deny or interfere with an individual's reproductive freedom, including a fundamental right to abortion and contraceptives. [3] This is in addition to existing protections under the state's inalienable right to privacy. [4]

The Reproductive Privacy Act ("RPA") specifies that the state shall not deny or interfere with a pregnant person's right to choose or obtain an abortion prior to viability, or when the abortion is necessary to protect the life or health of the pregnant person. [5] Unemancipated minors do not need parental consent to obtain an abortion. [6] Generally, an abortion is unauthorized if performed by someone other than the pregnant person who is not an authorized provider. [7] However, the California legislature has clarified state law to prevent pregnant people from being criminalized for their pregnancy outcomes. [8] A person shall not be subject to civil or criminal penalty for exercising, aiding, or assisting another in exercising their rights under the RPA. [9]

III. State Public Policy and Governing Law

The goal of these shield laws is to prevent any extraterritorial efforts to enforce laws in other states that restrict and penalize patients seeking abortion care, those who aid and support them, and those who provide abortions that are legal in California. To that end, the legislature has declared as against California state public policy, any interference with the state constitutional right to abortion [10] as well as any laws of another state that authorizes civil or criminal penalties related to an individual performing, supporting, or aiding in the performance of an abortion in California [11], for receiving, performing, knowingly engaging in conduct that aids or abets an abortion, or attempts to do any of these [12], and any other efforts of a foreign jurisdiction that prohibits, criminalizes, sanctions, authorizes a civil suit against, or otherwise interferes with access to or the provision of abortion. [13]

Furthermore, the shield laws proclaim that California law governs as it relates to actions that occur in California or individuals that are in California. California state courts shall not apply another state's law that violates California public policy under the RPA and that California law also governs in civil actions in this state resulting from receiving or seeking an abortion, performing, providing, or inducing an abortion, knowingly engaging in conduct that aids or abets those acts, or attempting to do any of these. [14] The law also asserts that California law governs in any actions in California against a person who provides or receives an abortion, attempts to do so, or supports someone doing so "by any means, including telehealth" if the provider was in a state where the care was legal when provided. [15]

IV. Civil Proceedings

If a patient, provider, or other individual is subject to a civil suit based on a violation of another state's laws restriction or penalizing abortion, the following shield laws may apply.

A. Requests for Information

Several laws aim to protect an individual's information related to abortion care from being disclosed to aid investigations and enforcement of out-of-state laws that are against California's public policy. Generally, under the RPA, a person shall not be compelled to identify, or provide information that would identify, an individual that has sought or obtained an abortion if the information is requested in proceedings based on another state's law that interferes with an individual's right to abortion under California law or a foreign penal civil action. [16] A foreign penal civil action is defined as a law in which the sole purpose is punishing an offense against public justice of that state. [17]

Under the Confidentiality of Medical Information Act, health care providers, health plans, contractors, and employers shall not release medical information related to an individual seeking or obtaining an abortion in response to a subpoena or request based on another state's law interfering with a person's rights under the RPA or a foreign penal civil action, subject to specified exceptions. [18] These protections also apply to the medical information of incarcerated individuals who seek and obtain an abortion. [19]

Moreover, when an out-of-state entity requests a subpoena be issued in California, that subpoena shall not be issued if it relates to a foreign penal civil action and would require disclosure of information related to abortion. [20] If a subpoena issued in litigation or legal action interferes or attempts to interfere with abortion services, regardless of the patient's location, a defendant may move to quash a motion or subpoena in that case. [21]

B. Civil Judgements

California state courts shall not enforce or satisfy a judgement received under another state's law that authorizes a civil action for receiving or performing an abortion, knowingly engaging in conduct that "aids or abets" an abortion or attempting to do any of these. [22] Further, state courts are required to grant a stay of enforcement of money judgements or liens on real property that are obtained against a person or entity for exercising a right, or aiding and abetting the exercise of a right guaranteed under the U.S. or California constitutions. [23] Although the U.S. Supreme Court no longer recognizes a Constitutional right to

abortion, California affords individuals a state constitutional right to privacy and specifically to abortion.
A defendant in a legal action or "abusive litigation" based on another state's law that interferes or attempts to interfere with abortion services that are lawful in California may initiate a civil action to recover three time the damages sought in the original suit plus costs and attorney's fees. [24] California courts have explicit authority to exercise jurisdiction and apply California law in these civil suits in connection to an "abusive litigation." [25]

V. Criminal Investigations and Proceedings

If a patient, provider, or other individual is subject to criminal prosecution based on another state's laws penalizing abortion, the following shield laws may apply.

A. Subpoenas, Warrants, and Other Court Orders

California's shield laws also protect against criminal investigations and prosecutions based on another state's laws that criminalize abortion. Health care providers, plans, contractors, and employers shall not release medical information related to an individual seeking or obtaining an abortion to law enforcement for the purpose of enforcing another state's law interfering with a person's rights under the RPA or a foreign penal civil action. [26] A state court, judicial officer, court employee or clerk, or authorized attorney shall not issue a subpoena pursuant to another state's law that is connected to a proceeding in another state against an individual for performing, aiding in the performance of an abortion, or receiving a lawful abortion in California. [27]

Any out-of-state order for a subpoena, warrant, wiretap, pen register trap-and-trace for surveillance, legal process, or request from law enforcement must include an affidavit or similar declaration that discovery is not in connection with an out-of-state proceeding relating to abortion that would be legal if provided in California. [28] An exception applies if the out-of-state proceeding is based in tort, contract, or on statute that would be actionable under California law and was brought by a patient who received an abortion or their legal representative. [29]

No magistrate shall issue an ex parte order authorizing interception of communications, as well as pen registers and trap-and-trace devices, for the purpose of investigating or recovering evidence of providing, facilitating, obtaining an abortion that is lawful under California law, or attempting or intending to do any of these. [30]

No warrant shall issue for items that pertain to an out-of-state investigation into obtaining, performing, supporting, or aiding in the performance of an abortion in California that is lawful in the state. [31] A judge shall not order a witness to appear in a criminal prosecution based on another state's laws that penalize performing, receiving, supporting, or aiding the performance or receipt of abortion lawful in California. [32]

B. Cooperation by State and Local Entities

California state and local public agencies shall not cooperate or provide information to any individual, agency, or department from another state on any abortion performed in California that is lawful in the state or that would be lawful if provided in California. [33] Public agencies and their employees are similarly prohibited from disclosing information about an abortion that is lawful in California to federal law enforcement agencies to the extent permitted by federal law. [34]

State and local government agencies shall not use any resources in furtherance of an investigation or proceedings that seek to impose liability or professional sanctions based on an abortion provided lawfully in California or that would be lawful if provided in California. [35] An exception exists for written requests by the subject of an investigation or proceeding. [36]

C. Other Digital Data

California's shield laws go beyond medical information to protect other digital data from out-of-state law enforcement.

California corporations providing electronic communications services or remote computing services shall not produce records to comply with a warrant issued by another state when that warrant relates to an investigation or enforcement against obtaining, performing, supporting, or aiding in the performance of an abortion in California that is lawful in the state. [37] Such corporations shall not assist with specified requests and orders issued pursuant to another state's investigation or enforcement of a violation of their law penalizing any action related to an abortion would be lawful if provided in California. [38]

D. Arrests

A magistrate shall not issue a warrant for the arrest of an individual whose alleged offense or conviction is a violation of another state's laws criminalizing an abortion that would be lawful under California law, "regardless of the recipient's location." [39] State and local law enforcement agencies and officers shall not knowingly arrest or knowingly participate in arresting a person for obtaining, performing, supporting, or aiding in the performance of an abortion provided in California that is lawful in the state. [40]

Similarly, bondsmen and bail agents are prohibited from apprehending, detaining, or arresting a fugitive based on such a law, subject to loss of eligibility for licensure, a fine of $5,000, and an aggrieved individual's private right of action. [41] If an individual is arrested in California, state law requires $0 bail for an individual arrested in connection with an out-of-state proceeding regarding obtaining, performing, supporting, or aiding in the performance of an abortion in California that is lawful in the state. [42]

E. Extradition

The Governor's Office, by executive order, has proclaimed that the Governor shall decline any request from another state's executive authority to issue a warrant for the arrest or surrender of an individual criminally charged with violating a law of that state involving the provision, receipt, or assistance with reproductive health care services, except where required by the U.S. Constitution or where the alleged acts would constitute a criminal offense under California's state law. [43]

VI. Licensing, Administrative, and Contracting Protections

Additional protections are in place to protect health care professionals and entities from the impacts of adverse actions that may be taken against them under another state's law restricting or penalizing abortion. Licensing boards and entities shall not deny an applicant for licensure or suspend, revoke, or otherwise impose discipline based on an adverse action taken against the licensee in another state [44] and any out-of-state action or conviction may not be the sole basis to remove a provider from medical staff or otherwise deny or restrict staff privileges. [45] Health plans and insurers shall not terminate or decline to renew a contract with, nor discriminate against such a provider [46], including professional liability insurers that may not terminate or refuse to renew, nor increase costs or deny coverage for liability for damages because the health care practitioner or entity provides abortion care. [47] Additionally, in assessing such an adverse action or judgement in another state, California's Department of Health Care Services may elect not to suspend individual or entities participating in Medi-Cal. [48]

VII. Privacy

The California legislature has enacted several laws pertaining to privacy of medical records and consumer data outside the context of requests and orders issued as part of legal proceedings or by law enforcement.

A. Medical Information

California has passed legislation to prevent abortion-related medical information from being shared automatically across state lines through electronic health record systems and exchange of health information. Providers, plans, contractors and employers shall not knowingly share medical information with any out-of-state entity, including other health care providers, that would identify an individual and is related to seeking, obtaining, providing, supporting, or aiding in an abortion that is lawful in California. Some exceptions exist if the patient authorizes the disclosure, or information is shared for billing, accreditation, or bona fide research. [49] While this provision is currently in effect, there is a delay in enforcement until January 31, 2026, if the covered entities are working diligently and in good faith to come into compliance. [50]

Businesses that store or maintain medical information, including electronic health records systems, are required to develop capabilities, policies, and procedures to facilitate confidentiality for medical information related to abortion. [51]

California has also established a Data Exchange Framework to facilitate information exchange across health care and social services providers in California. Entities that participate in California's Data Exchange Framework are not obligated to exchange health information related to abortion. [52]

B. Consumer Data

California law contains privacy protections for data related to abortion that is not necessarily stored in a patient's medical record. For example, businesses that maintain medical information for consumers, offer hardware or software (including mobile apps) to consumers, or that otherwise offer digital services related to mental health or reproductive or sexual health must comply with the Confidentiality of Medical Information Act. [53] California law also prohibits entities from collecting, using, disclosing, or retaining the personal information of a person who is physically located at or within a precise geolocation of a family planning center, as defined, except to provide the goods or services that person requested. [54]

Moreover, the legislature amended the California Consumer Privacy Act ("CCPA") in 2023 to protect consumer data related to abortion. These amendments make clear that consumer information related to accessing, procuring, or searching for abortion services do not broadly fall within the CCPA's exemptions [55], and more specifically that such information cannot be used to support an assertion that a person is at risk or danger of death or serious physical injury under the CCPA's emergency access exemption. [56]

VIII. Conclusion

With the ongoing legal and political battles surrounding abortion and other politicized health care services, patients, providers, and the attorneys who counsel them can expect uncertainty and legal compliance challenges. To keep patients and providers safe, California will look to previously enacted efforts like the California Freedom of Access to Clinic and Church Entrances ("FACE") Act [57] and the Safe At Home program [58] as well as shield laws like the ones discussed in this article – many of which are largely untested in the courts. With the first cases of civil actions and criminal prosecutions being filed against abortion providers in states where abortion remain legal [59], it is not yet clear how state laws will continue to interact with each other and how any federal actions to restrict abortion will impact California. In the meantime, California's state leaders are back for a new legislative session that is sure to see the introduction of additional shield-law-style bills.

Endnotes

[1] Dobbs v. Jackson Women's Health Organization, 597 U.S. 215 (2022); Allison McCann and Amy Schoenfeld Walker, Abortion Bans Across the Country, New York Times (Jan. 6, 2025), https://www.nytimes.com/interactive/2024/us/abortion-laws-roe-v-wade.html.
[2] California Future of Abortion Council, Statement on Passage of California State Budget, (Jun. 29, 2022), https://www.cafabcouncil.org/post/california-future-of-abortion-council-statement-on-passage-of-california-state-budget.
[3] California Constitution Article I, §1.1 (Proposition 1, 2022).
[4] California Constitution Article I, §1 (1972).
[5] Health & Safety Code §123466(a).
[6] American Academy of Pediatrics v. Lungren, 16 Cal.4th 307 (1997) (finding that requiring parental consent for an unemancipated minor to obtain an abortion violates a minor's right to privacy); See also Stats. 2023, Ch. 260, Sec. 12. (SB 345) (repealing Health & Safety Code §123450).
[7] Health & Safety Code §123468.
[8] Government Code §27491; Health & Safety Code §103000; Health & Safety Code §103005.
[9] Health & Safety Code §123467(a)-(b); Penal Code §187.
[10] Civil Code §1798.301.
[11] Penal Code §13778.2(c)(1).
[12] Health and Safety Code §123467.5(a).
[13] Civil Code §1798.302.
[14] Health & Safety Code §123467.5(b).
[15] Health & Safety Code §123468.5.
[16] Health & Safety Code §123466(b).
[17] Code of Civil Procedure §2029.200.
[18] Civil Code §56.108(a).
[19] Penal Code §3408.
[20] Code of Civil Procedure §§2029.300 and 2029.350.
[21] Civil Code §1798.304.
[22] Health & Safety Code §123467.5(b)(2).
[23] Code of Civil Procedures §1710.50.
[24] Civil Code §§1798.303-1798.308.
[25] Civil Code §1798.306.
[26] Civil Code §56.108(b).
[27] Penal Code §13778.2(c)(2).
[28] Penal Code §13778.3(e).
[29] Penal Code §13778.3(d).
[30] Penal Code §629.52; Penal Code §638.52.
[31] Penal Code §1524.
[32] Penal Code §1334.2.
[33] Penal Code §13778.2(b); Penal Code 13778.3(b).
[34] Penal Code §13778.2(b).
[35] Penal Code §13778.3(b).
[36] Penal Code §13778.3(c).
[37] Penal Code §1524.2.
[38] Penal Code §§1546.5 and 13778.3(f).
[39] Penal Code §547.5(b).
[40] Penal Code §13778.2(a).
[41] Penal Code §547.5(c); Penal Code §1299.02(d).
[42] Penal Code §1269b(f)(2).
[43] Cal. Exec. Order No. 12-22 (June 27, 2022).
[44] Health & Safety Code §§1220.1 and 1265.11; Business & Professions Code §§850.1, 2253, 2746.6, 2761.1, and 3502.4.
[45] Business & Professions Code §805.9.
[46] Health and Safety Code §12375.61; Insurance Code §10133.641.
[47] Insurance Code §11589.1.
[48] Welfare & Institutions Code §§14043.6 and 14123.
[49] Civil Code §56.110(a).
[50] Civil Code §56.110(d).
[51] Civil Code §56.101(c).
[52] Civil Code §56.110.
[53] Civil Code §§56.05-.06.
[54] Civil Code §1798.99.90.
[55] Civil Code §1798.145(a)(2)(A)-(C).
[56] Civil Code §1798.145(a)(1)(D)(ii).
[57] Penal Code §423 et. seq.
[58] Government Code §5215.2; The California Secretary of State Safe at Home Program, https://www.sos.ca.gov/registries/safe-home.
[59] Pam Belluck and Mary Beth Gahan, Texas Judge Fines New York Doctor and Orders Her to Stop Sending Abortion Pills to Texas, New York Times (Feb. 13, 2025), https://www.nytimes.com/2025/02/13/health/texas-new-york-abortion-pills-lawsuit.html.

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