Health Law Committee Annual Report on Developments in California Health Care Law – 2012

H. Thomas Watson, Kelly A. Ryan, Steven Goby, Jeanne L. Vance, and Craig B. Garner

This article reviews California health care case law and significant developments in California health care law for 2012.

Annual Review of Appellate Decisions

By: H. Thomas Watson and Kelly A. Ryan

Pending California Supreme Court Health Law Matters

The following two health law matters are currently pending before the California Supreme Court:

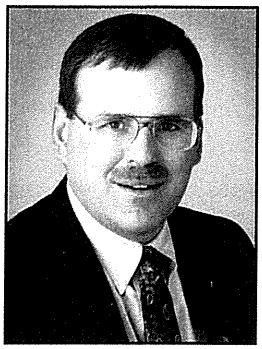
***El-Attar v. Hollywood Presbyterian Medical Center*, 198 Cal. App. 4th 664 (2011), *review granted*, 130 Cal. Rptr. 3d 750 (Cal. Nov. 30, 2011), No. S196830.**

The hospital's governing board denied Dr. El-Attar's application for reappointment to the medical staff on the grounds that his medical practice threatened both patient safety and the hospital's continued eligibility for Medicare and Medi-Cal funding. The medical staff disagreed with that decision. When Dr. El-Attar requested a peer review hearing, the medical staff's Medical Executive Committee (MEC) determined that the governing board should arrange for those proceedings even though the bylaws required the MEC to select the hearing panel members and the hearing officer. The ensuing peer review proceedings encompassed more than thirty hearings, lasted more than two years, and ended with the board's decision being upheld. That decision was affirmed by an administrative appeals board, the hospital governing board, and the superior court. The court of appeal, however, reversed on the ground that the selection of the hearing panel members and hearing officer by the governing board rather than the MEC violated the bylaws.

The California Supreme Court granted review, and will decide the following issue:

> When formal peer review is needed to determine whether a physician is competent to continue practicing in a hospital, may the hospital's governing board initiate the peer review by selecting the medical staff physician reviewers and a hearing officer if the medical staff does not, where the medical staff's bylaws specify the medical staff as the selecting body?

Briefing is complete. Oral argument is expected to take place in 2013, with a decision by the California Supreme Court to be filed within ninety days thereafter.



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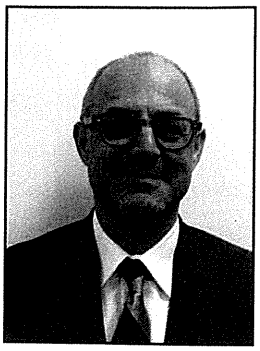

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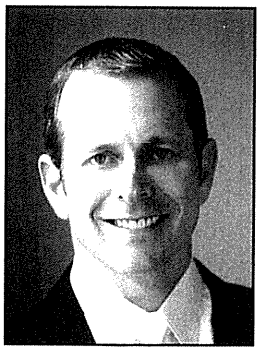

Craig B. Garner

Craig Garner is an attorney, adjunct professor of law and former hospital CEO specializing in issues surrounding modern American health care and the ways it should be managed in its current climate of reform. Additional information about Craig's law practice, as well as biographical information, appears at www.craiggarner.com.

***Fahlen v. Sutter Central Valley Hospitals*, 208 Cal. App. 4th 557 (2012), *review granted*, 149 Cal. Rptr. 3d 614 (Cal. Nov. 14, 2012) No. S205568.**

A hospital declined to renew Dr. Fahlen's medical staff privileges in accordance with the recommendation of the Medical Executive Committee (MEC) of the hospital's medical staff, and that decision was upheld by the hospital's board of trustees after internal peer review proceedings. Dr. Fahlen did not seek judicial review of that administrative decision. Instead, he brought a whistleblower suit against the hospital, claiming that his privileges were denied in retaliation for his complaints about nursing issues. The hospital filed an anti-SLAPP motion seeking to dismiss the complaint, which the trial court denied. The court of appeal affirmed in part, holding that Dr. Fahlen's whistleblower cause of action under California Health and Safety Code section 1278.5 could proceed despite his failure to exhaust administrative remedies and the holding in *Westlake Community Hospital v. Superior Court*, 17 Cal. 3d 465 (1976). The *Fahlen* court expressed disagreement with *Nesson v. Northern Inyo County Local Hospital District*, 204 Cal. App. 4th 65 (2012) (discussed below) on this issue.

The California Supreme Court granted the hospital's petition for review, which presented the following issue:

> Medical staff privileges are the product of peer review and a physician may pursue damages on the basis that a peer review action was maliciously motivated only if he first secures mandamus relief. This exhaustion rule governs statutory damages claims unless abrogation is express or necessarily implied. Health and Safety Code section 1278.5 allows damages claims by physicians who prove that a hospital or official harmed his economic interests out of retaliatory malice. Abrogation is neither express nor necessary to give effect to the statute. By section 1278.5, did the Legislature abrogate the exhaustion rule?

The parties' California Supreme Court briefing is underway, with the opening brief due on January 14, 2013. A decision is not expected until 2014.

California Courts of Appeal health law decisions

The California Courts of Appeal published numerous cases in 2012 deciding health law issues, including the following:

***Young v. Tri-City Healthcare District*, 210 Cal. App. 4th 35 (2012).**

The court of appeal held that the anti-SLAPP statute, California Civil Procedure Code section 425.16, does not apply to a cause of action seeking administrative writ relief from a hospital's summary suspension of medical staff privileges because that cause of action does *not* arise out of action taken in furtherance of the rights of petition or free speech in connection with peer review. The court distinguished *Kibler v. Northern Inyo County Local Hospital District*, 39 Cal. 4th 192 (2006) on the ground *Kibler* applied the anti-SLAPP statute to a cause of action seeking tort damages for wrongful peer review action, rather than reinstatement to the medical staff. Several depublication requests are pending (case no. S207243).

***Lee v. Board of Registered Nursing*, 209 Cal. App. 4th 793 (2012).**

The Board of Registered Nursing may revoke a nurse's license under California Business and Professions Code sections 820-21 based on her refusal to comply with an administrative law judge's order requiring her to submit to a mental fitness examination.

***Pomona Valley Hospital Medical Center v. Superior Court*, 209 Cal. App. 4th 687 (2012).**

California Evidence Code section 1157 exempts from discovery the records of a hospital's Institutional Review Board (IRB) regarding the review and approval of biomedical clinical investigations, even though federal law requires the IRB to include lay members who are not affiliated with the hospital, and even though the FDA has access to all IRB records.

***Rand v. Board of Psychology*, 206 Cal. App. 4th 565 (2012).**

The Board of Psychology properly revoked a psychologist's license for actions taken while acting as a special master in one family law matter which amounted to unprofessional conduct creating the appearance of bias, and for violating ethical rules by giving unqualified diagnosis testimony without first examining the patient in another family law matter.

***Chakalis v. Elevator Solutions, Inc.*, 205 Cal. App. 4th 1557 (2012).**

Fault may not be allocated to a nonparty treating physician unless the plaintiff proves all elements of a medical malpractice claim and the jury is properly instructed on the requirements of a medical malpractice claim.

***Sulla v. Board of Registered Nursing*, 205 Cal. App. 4th 1195 (2012).**

The Board of Registered Nursing may revoke a nurse's license under California Business and Professions Code section 2762 based on a single, isolated conviction of misdemeanor drunk driving stemming from a single-car accident, regardless of the administrative law judge's finding that the misconduct and

conviction "were not 'substantially related to the qualifications, functions or duties' of a nurse," because section 2762 creates a conclusive presumption that alcohol-related convictions amount to unprofessional misconduct.

***Bush v. Horizon West*, 205 Cal. App. 4th 924 (2012).**

The trial court properly denied a motion to compel arbitration where: (1) the patient's daughter, who sued for negligent infliction of emotional distress based on her alleged observation of harm to her mother caused by the defendant's neglect, had never signed an arbitration agreement, and (2) arbitration of the patient's lawsuit for elder abuse pursuant to the arbitration agreement the patient signed could conflict with the results of the daughter's lawsuit.

***Johnson v. Alameda County Medical Center*, 205 Cal. App. 4th 521 (2012).**

County medical institution is immune from liability under California Government Code section 854.8 for the sexual assault of a patient by a fellow patient where the plaintiff failed to trigger an exception to the general immunity rule by identifying either a negligent act or omission by a specific county employee, or the violation of any statute or regulation regarding a faulty door lock that permitted the perpetrator to gain access to her room.

***People ex rel. Trutanich v. Joseph*, 204 Cal. App. 4th 1512 (2012).**

The owner of a marijuana store can be permanently enjoined from operating his business under the Narcotics Abatement Law, the Public Nuisance Law, and the Unfair Competition Law because the Compassionate Use Act, California Health and Safety Code, section 11362.5, does not authorize the sale of marijuana, and the store owner is not a "primary caregiver" within the meaning of the Medical Marijuana Program Act, *id.* § 11362.7.

***California Ass'n for Health Services at Home v. State Department of Health Care Services*, 204 Cal. App. 4th 676 (2012).**

The State Department of Health Care Services (DHCS) did not abuse its discretion by failing to consider provider costs or otherwise comply with *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), when conducting its annual review of Medi-Cal reimbursement rates paid to providers of home health agency services because the Medicaid Act, 42 United States Code section 1396a(a)(30)(A) (2006), does not require states to utilize any particular methodology when setting reimbursement rates. Nevertheless, the DHCS acted arbitrarily and capriciously by relying on outdated and irrelevant data when concluding that its rates were sufficient to ensure that Medi-Cal recipients had the same access to care as members of the general public in the same geographic area.

***Scott S. v. Superior Court*, 204 Cal. App. 4th 326 (2012).**

The trial court is required to find medical necessity based on admissible evidence before authorizing a conservator appointed under the Lanterman-Petris-Short Act, California Welfare and Institutions Code, section 5000, to consent to nonroutine, nonemergency medical treatment of a conservatee who lacks capacity to give informed consent. A physician's written declaration stating that amputation of the conservatee's toe was medically necessary was inadmissible hearsay and therefore insufficient to support a finding of medical necessity.

***K.G. v. Meredith*, 204 Cal. App. 4th 164 (2012).**

The trial court is required to find decisional incapacity before designating medical treatment disabilities to which temporary and one-year conservatees and proposed conservatees may be subject under the Lanterman-Petris-Short Act, California Welfare and Institutions Code, section 5357.

***Nesson v. North Inyo County Local Hosp. Dist.*, 204 Cal. App. 4th 65 (2012).**

In *Kibler v. Northern Inyo County Local Hospital District*, 39 Cal. 4th 192 (2006), the California Supreme Court held that hospital peer review procedures constitute an "official proceeding authorized by law," and therefore lawsuits challenging peer review decisions are subject to early dismissal under the anti-SLAPP statute. In *Nesson*, the plaintiff doctor sued the defendant hospital for breach of contract, breach of the covenant of good faith and fair dealing, violation of California Health and Safety Code section 1278.5, violation of the Unruh Civil Rights Act, and violation of the Fair Employment and Housing Act, seeking damages arising from the adverse peer review process. The court of appeal concluded that these claims all arose from the summary suspension of plaintiff's privileges through the peer review process and are therefore covered by the anti-SLAPP statute.

Note: As discussed above, the court of appeal in *Fahlen*, 208 Cal. App. 4th 557, expressly disagreed with *Nesson* with respect to the need to exhaust administrative remedies before filing a retaliation claim under California Health and Safety Code section 1278.5, and the California Supreme Court granted review in *Fahlen*.

***Kaiser Foundation Health Plan, Inc. v. Superior Court*, 203 Cal. App. 4th 696 (2012).**

California Civil Procedure Code section 425.13 precludes a plaintiff from pleading a claim for punitive damages in an

"action for damages arising out of the professional negligence of a health care provider" unless the plaintiff first submits evidence establishing "that there is a substantial probability that the plaintiff will prevail on the claim." However, plaintiffs do *not* have to satisfy the statutory requirement of showing probability of success where the punitive damages claim is brought against a *health care service plan* because such a plan "does not directly provide medical care to its subscribers. Instead, the Health Plan contracts with other . . . entities to deliver medical care to subscribers who enroll in its plans."

***Wang v. Heck*, 203 Cal. App. 4th 677 (2012).**

Plaintiffs, who were injured in an accident caused by another motorist who lost control of his vehicle due to an epileptic fit, sued the neurologist who prepared a Department of Motor Vehicles medical evaluation form for the motorist stating that epilepsy did not affect his ability to drive safely. The court of appeal held that the litigation privilege, California Civil Code § 47(b), bars the plaintiffs' tort claim against the neurologist.

***Walker v. Sonora Regional Medical Center*, 202 Cal. App. 4th 948 (2012).**

A hospital that performs lab tests for a patient's personal physician is not liable under an ostensible agent theory for the physician's failure to inform the patient of the lab results.

Ninth Circuit Court of Appeals health law decisions

The Ninth Circuit Court of Appeals published the following two significant decisions addressing California health law issues:

***Managed Pharmacy Care v. Sebelius*, Nos. 12-55067, 12-55068, 12-55103, 1255315, 12-55331, 12-55332, 12-55334, 12-55335, 12-55535, 12-55550, 12-55554, 2012 WL 6204214 (9th Cir. Dec. 13, 2012).**

The Ninth Circuit Court reversed the district court's decisions in four cases and vacated preliminary injunctions prohibiting the California Department of Health Care Services (DHCS) from implementing Medi-Cal provider reimbursement rate reductions authorized by the California legislature. These cases included *Douglas v. Independent Living Centers of Southern California, Inc.*, 132 S. Ct. (2012), which was sent back to the Ninth Circuit by the Supreme Court last year after U.S. Health and Human Services Secretary, Kathleen Sebelius, (Secretary), approved the State's request to reduce Medi-Cal rates.

Asserting claims against the Secretary under the Administrative Procedure Act (APA) and against the Director of DHCS under the Supremacy Clause, various Medi-Cal providers and beneficiaries claimed that the reimbursement rate reductions did not comply with 42 United States Code section 1396a(a)(30)(A) (hereafter section 30(A)). The plaintiffs relied on *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), which interpreted section 30(A) as requiring a state seeking to reduce Medicaid reimbursement rates first to consider the costs of providing medical services subject to the rate reductions.

The Ninth Circuit held that the cases before them were not controlled by *Orthopaedic* because *Orthopaedic* did not consider the Secretary's interpretation of section 30(A) and her approval of the rates. Agreeing with the D.C. Circuit, the panel held that the Secretary's approval of California's requested reimbursement rates—including her permissible view that prior to reducing rates, states need not follow any specific procedural steps, such as considering providers' costs—is entitled to deference under *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), and ruled that the Secretary's approval complies with the APA. Leaving open the issue of a Medicaid provider's private right of action, the panel further found that the plaintiffs were unlikely to succeed on the merits of their Supremacy Clause claims against the Director of DHCS because, even assuming that the Supremacy Clause provides a private right of action, the Secretary reasonably determined that the State's reimbursement rates comply with section 30(A). Finally, the panel held that the none of the plaintiffs had a viable takings claim because Medicaid, as a voluntary program, does not create property rights.

If final, this decision allows California to move forward with Medi-Cal provider rate reductions, including those enacted in the 2011-2012 budget (i.e., Assembly Bill 97). It is unclear if DHCS will seek to implement any of the provider rate reductions retroactively to the effective date of the legislation; however, the current year budget assumes retroactive implementation.

***Harlick v. Blue Shield of California*, 686 F.3d 699 (9th Cir. 2012).**

The court held that California's Mental Health Parity Act, Health and Safety Code, section 1374.72; Title 28, California Code of Regulations, section 1300.74.72 (2012), requires health care service plans to cover all "medically necessary treatment" for all listed "severe mental illnesses," but allows plans to apply the same financial conditions—such as deductibles and lifetime benefits—as those applied to physical illnesses. In this case, Blue Shield was ordered to pay for care at a residential treatment

facility that was found to be medically necessary for the treatment of the patient's anorexia nervosa, even though residential care was excluded as a covered service under Blue Shield's benefit plan.

Regulatory Developments

By: Steven Goby

Department of Managed Health Care, Title 28, California Code of Regulations, section 1300.74.73. Pervasive Developmental Disorder and Autism Coverage [Effective September 6, 2012]

This Rule was promulgated as an emergency regulation primarily to clarify Health and Safety Code section 1374.73, a section of the Knox-Keene Health Care Service Plan Act of 1975, related to health plan coverage for the diagnosis and medically necessary treatment for health plan enrollees with pervasive developmental disorder or autism ("section 1374.73") through the use of applied behavioral analysis treatment (known as "ABA Therapy"). Passage of the Health and Safety Code section caused some uncertainty regarding whether it served to supersede provisions in Health and Safety Code section 1374.72, which is the California's Mental Health Parity Law ("California Mental Health Parity Law"). Although section 1374.73 expressly exempted health care service plan contracts in the Healthy Families Program and health care benefit plans or contracts entered into with the Board of Administration of the Public Employees' Retirement System ("PERS"), the Department of Managed Health Care took the position that section 1374.73 did not supersede any requirements of the California Mental Health Parity Law (i.e., Health and Safety Code section 1374.72). To clear up any uncertainty about the impact of section 1374.73, the Department of Managed Health Care passed Rule 1300.74.73 to clarify that section 1374.73 did not affect, reduce or limit the obligation of Health Plans contracting for the Healthy Families Program or for PERS to provide coverage for the treatment of pervasive developmental disorder and autism pursuant to the California Mental Health Parity Law (i.e., Health and Safety Code section 1374.72).

Health Care Reform Hits California Medi-Cal Enrollment; Rules Significantly Change January 1, 2013

By: Jeanne L. Vance,

Medi-Cal enrollment rules for California healthcare providers have significantly changed effective January 1, 2013. The changes impact providers who are currently enrolled in the Medi-Cal program to bill the fee-for-service program, those who desire to do so in the future, and providers who do not themselves bill the Medi-Cal program but who order and refer Medi-Cal beneficiaries for Medi-Cal-covered benefits. Effective January 1, the California Department of Health Care Services ("DHCS") implemented new Medicaid enrollment requirements of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 ("PPACA").[1]

Enrollment Screening Levels

California has implemented federal Medicaid rules for a three-tiered enrollment system for increased scrutiny of applicants to the Medi-Cal program depending upon the risk of program abuse.[2] "High" risk providers are newly enrolling home health agencies and durable medical equipment ("DME") providers; "moderate" risk providers are ambulance suppliers, community mental health centers, comprehensive outpatient rehabilitation facilities, hospice organizations, independent clinical laboratories, physical therapists, portable x-ray suppliers, revalidating home health agencies, and revalidating DME suppliers; other enumerated providers are in the "limited" categorical risk category.[3] Moderate and high risk providers are subject to pre- and post-enrollment site visits.[4] In addition, DHCS conducts criminal background checks on 5% of owners of high risk providers; these same individuals will be fingerprinted as a part of Medi-Cal enrollment; however, these program integrity provisions had not yet been implemented at the time of submission of this summary.[5]

A specific provider's risk category can increase to the "high" risk category based on program integrity reasons such as existing Medicaid overpayment, program exclusions, and if DHCS receives a "credible allegation of fraud" by the provider.[6]

Revalidation

Healthcare providers that are currently enrolled in the Medi-Cal program now must validate the contents of their DHCS Medi-Cal enrollment file every five years.[7] DHCS indicates in public comment that it is developing a short-form application for this purpose, and that if the content on this short-form application matches what is in DHCS files, the provider will not need to complete an entire Medi-Cal enrollment application.[8] In addition, DHCS indicates that it will attempt to revalidate providers using Medicare enrollment record data from the Centers for Medicare and Medicaid Services, and when it is able to do so the provider will not need to separately revalidate for Medi-Cal.[9]

Ordering/Referring Providers Required to Be Enrolled

For the first time, practitioners that do not bill the Medi-Cal program themselves, but that order or refer Medi-Cal beneficiaries for Medi-Cal services are now required to be enrolled in Medi-Cal.[10] The consequence of failure to enroll is that the laboratory, pharmacy or other provider to whom the beneficiary is referred will not be paid by the Medi-Cal program for the item or service. DHCS is developing a way for such providers to determine whether or not an ordering or referring provider is Medi-Cal enrolled, and that DHCS will not implement payment edits until this system is available.[11]

Enrollment Fees

Providers submitting Medi-Cal enrollment applications are now subject to enrollment fees of $523 (adjusted annually for inflation), with certain exceptions.[12] Providers submitting enrollment applications without the fee will have their applications rejected.[13] This is not a defect that is subject to remedy other than submission of a new later application. Providers that are exempt from payment of the fee include those enrolled in Medicare, another state Medicaid program or a Children's Health Insurance Program, individual physicians and non-physician practitioners who have already paid an enrollment fee to one of these programs and can provide proof of payment.[14] The application fee applies to revalidation applications and applications for new or changes to locations.

Endnotes

1 Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (codified as amended in scattered sections of U.S.C.).

2 42 C.F.R. § 455.415; CAL. WELF. & INST. CODE § 14043.38.

3 *Id.*

4 CAL. WELF. & INST. CODE § 14043.43(b).

5 *Id.*

6 CAL. WELF. & INST. CODE § 14043.38(c).

7 42 C.F.R. § 455.414.

8 Comments of Tanya Homman, Chief, Provider Enrollment, DHCS, Affordable Care Act Implementation, Provider Enrollment Stakeholders Meeting, December 10, 2012.

9 Comments of Anne Robertson, DHCS, Affordable Care Act Implementation, Provider Enrollment Stakeholders Meeting, December 10, 2012.

10 CAL. WELF. & INST. CODE §§ 14043.36(b), 14043.26(f)(4)(F), 14043.7(a), and 14043.26(f)(4)(E).

11 Comments of Richard Moritz, Chief, Policy and Administrative Branch, Provider Enrollment Division, DHCS, Affordable Care Act Implementation, Provider Enrollment Stakeholders Meeting, December 10, 2012.

12 CAL. WELF. & INST. CODE § 14043.38(c); 42 C.F.R. § 455.460.

13 CAL. WELF. & INST. CODE § 14043.26(f)(4)(F).

14 DHCS Provider Bulletin – Medi-Cal Application Fee Requirements for Compliance with 42 C.F.R. § 455.460 (Nov. 29, 2012).

Medicaid Expansion: Tracing the True Value of a Free Lunch

By: CRAIG B. GARNER

By 2014, the Affordable Care Act will rely heavily upon Medicaid as the program continues to evolve from its humble origins in 1965 to become part of the new foundation of a restructured American health care system. In the three short years since the passage of the Affordable Care Act, Medicaid has become the "dark horse" successor to Medicare in its attempt to reform a rapidly failing system while at the same time expanding health care to the nation's estimated 50 million uninsured. Nearly five decades since its creation by an act of Congress, Medicaid is at last poised to steal the spotlight away from Medicare and change the course of modern American health care for decades to come.

The last fifty years have seen Medicare emerge as the basic blueprint upon which the nation's health care system rests. Its passage in 1965[1] expanded the already-existing federal and state welfare structure in the United States by providing coverage to 19 million people aged 65 and over in its inaugural year alone. Simultaneously, but with far less fanfare, Medicaid offered similar access to health care on a state level for qualifying low-income individuals. Both Medicare[2] and Medicaid[3] have evolved considerably over the past 47 years, responding to changes in the nation's economic, social and political climate over time, with the most recent iteration of Medicare starting to take shape under the Value Based Purchasing Programs for hospitals[4] and physicians.[5] However, the new and improved Medicaid[6] has been enjoying its own growth spurt of late. Having long since outstripped its role as insurance for low income individuals, Medicaid stands ready to replace Medicare as modern health care's weathervane, assuming it can overcome the burden of its historical societal stigma and the general disdain with which the vast majority of health care providers across the nation currently regard it.[7]

In addition to Medicaid's main statutory authority under federal law,[8] necessary clarification for all practitioners exists within Title 42 of the Code of Federal Regulations, Parts

433 (State Fiscal Administration), 438 (Managed Care), 441 (Services) and 447 (Payments), to name but a few. Yet, for most Californians, the term "Medicaid" existed outside ordinary healthcare vernacular prior to the Affordable Care Act, as the delivery of care to residents who qualify financially, as well as families with dependent children, the aged, blind or disabled, falls under the aegis of the state's "Medi-Cal" program.[9]

Medi-Cal Takes California a Step Further

As early as 1850, California had confirmed its commitment to state hospitals by granting public health authority (including quarantine) for its leadership and imposing a mandatory pre-paid plan upon immigrants who arrived by sea, not to mention designing other public programs for those who arrived from the north, south and east.[10] By 1917, the California District Court of Appeals confirmed the state's conviction[11] to address the needs of public health by stating:

> It has never been, nor will it ever be, questioned that, among the first or primary duties devolving upon a state is that of providing suitable means and measures for the proper care and treatment, at the public expense, of the indigent sick, having no relatives legally liable for their care, support, and treatment, those who are infirm and helpless from the ravages of advancing years and without means of their own. . . . Nor can it for a moment be doubted that it is the duty of the state to take all necessary steps for the promotion of the health and comfort of its inhabitants and to make such regulations as may be conceived to be essential to the protection of the state and the people thereof, so far as such result may be attained, against the visitations and prevalence of deadly epidemical and endemical diseases, and to take and prosecute such health and sanitary steps and measures as will result in stamping them out. . . . These are duties which the state owes to its inhabitants for the . . . preservation of their general happiness and welfare; and, as is true of the duty of the state in the matter of taking proper care of the impecunious or indigent who are afflicted with disease and who have no means for caring for themselves or relatives legally responsible for such care, they are duties which the state may perform in the exercise of its sovereignty, even in the absence of direct constitutional authority therefore - indeed, duties which it may discharge under its inherent power of police.[12]

After Congress passed Medicaid, California's leadership created the Medi-Cal program during its 1965 Second Extraordinary Session "in order to establish a program of basic and extended health care services for recipients of public assistance and for medically indigent persons . . . and, by meeting the requirements of federal law, to qualify California for the recipt [sic] of federal funds made available under title XIX of the Social Security Act."[13] Since then, Medi-Cal has existed throughout different parts, chapters and articles of the California Welfare and Institutions Code.[14]

Medi-Cal's Struggle to Survive

While California has generally supported the Medi-Cal program since its inception, those financing the state's commitment to public health have been both tenacious and creative in their attempts to provide care for the estimated 9.2 million beneficiaries[15] who make up nearly 25% of the state's population that were enrolled in the program by Fiscal Year 2010.[16] Over time, this has included the Medi-Cal Disproportionate Share Program,[17] the Private Hospital Supplemental Fund,[18] the Distressed Hospital Fund,[19] the Construction and Renovation Reimbursement Program,[20] the Hospital Quality Assurance Fee Program,[21] and most recently stabilization funding,[22] among other similar programs.[23]

Medicaid Expansion Under the Affordable Care Act

Regardless of California's decades of tireless efforts to increase the scope and stability of coverage for Medi-Cal beneficiaries, the recent proliferation of the use of the term "Medicaid" is largely a result of the effects of the Affordable Care Act. Across the nation, preparation has begun for an unprecedented expansion of Medicaid within a regulatory system already riddled with complexity and questionable financial stability. If that were not enough, last summer's landmark United States Supreme Court decision[24] not only cemented the nation's familiarity with the term "Medicaid Expansion," but it also sparked a constitutional battle that combined health care and federalism in ways reminiscent of the party divisiveness seen between the states preceding the American Civil War. In deciding that Congress has the authority to offer funding for states to expand Medicaid by 2014 without imposing retroactive financial conditions,[25] the Supreme Court created a federal chasm that at least four of the Justices did not believe possible.[26]

The resultant cracks are already beginning to form, though not because the four dissenters simply miscalculated the will

of the individual states. Even after recognizing the historical importance of Medicaid, Congress and the Judicial Branch perhaps failed to embrace just how fundamental the program may soon become. To be sure, Medicaid is but one of several theoretical options for the estimated 50 million Americans without health insurance who intend to avoid a $695 penalty/tax beginning in 2016.[27] However, it is certainly on the short list of practical solutions for the tens of millions who are left without health insurance if and when their employer chooses a $2,000 fine per employee rather than bear the cost of providing health care benefits in the workplace.[28] With a proven 47-year track record, the Medicaid program appears to be the frontrunner when compared with the Affordable Insurance Exchanges[29] and the Consumer Operated and Oriented Plans (also known as CO-OPs).[30] When history is taken into account, Medicaid Expansion emerges as potentially the most reliable solution starting January 1, 2014.

Too Good to Be True?

As health insurance goes, Americans could do worse than Medicaid. Those who qualify for coverage under Medicaid Expansion in 2014 will have affordable access to 29 different types of medical care, ranging from inpatient hospital services and outpatient care to dental services and certain defined forms of respiratory care.[31] Moreover, for all 50 states and the District of Columbia, the Federal Government has offered to bear 100% of the added expense for newly eligible Medicaid beneficiaries through 2016, 95% in 2017, 94% in 2018, 93% in 2019 and 90% in 2020 and thereafter.[32] To most observers, including the U.S. Supreme Court,[33] this financial incentive alone would seem likely to ensure the success of Medicaid Expansion throughout the states.

At first blush it also follows that primary care and other qualifying physicians would champion Medicaid Expansion, as the Affordable Care Act requires states to increase the professional Medicaid rate so that it is equal to Medicare's level of reimbursement for these same basic services, subject to certain conditions.[34] To help ensure the access needed to meet the expected higher demands for care in Medicaid, the Affordable Care Act requires states to pay "qualified" physicians Medicaid fees at least equal to Medicare rates for primary care services, beginning in 2013. Such an action has the dual goal of boosting physician participation in Medicaid and providing increased support for those physicians who already participate and may wish to expand their Medicaid services.

Likewise, few should complain about the fact that the fee increase is federally funded. Family physicians, internists and pediatricians qualify, as well as certain specialists, provided (1) they are Board-certified, or (2) at least 60% of the Medicaid codes they billed in the previous year were primary care codes identified in the Affordable Care Act. These corresponding 146 services include visits and other care-related functions central to primary care practices. Services provided by non-physicians under the supervision of qualified physicians are eligible for the higher fees.[35] This also applies to physicians in managed care organizations as well as the coinsurance to which physicians may be entitled for treating dual eligible beneficiaries.[36]

While Medicaid is poised to rise to the occasion afforded it by changes to the nation's health care structure under the Affordable Care Act, only time will tell if it has the necessary strength to do so. Even with the wealth of financial promises at the ready, industry experts speculate that a significant number of physicians will not accept new Medicaid patients under the program's expansion for a number of reasons. The primary concern, at least for now, remains the historically low levels at which the program reimburses.[37] Under Medicaid Expansion, the rate increase physicians are due to receive[38] means little if *Medicare* reimbursements plummet due to partisan politics.[39] Hospitals, too, are wary, as they are required to treat emergency Medicaid patients under the Emergency Medical Treatment and Active Labor Act ("EMTALA"),[40] but are not always thrilled with the reimbursement structure for treating patients in this category.[41]

In addition to financial concerns, the historical stigma attached to Medicaid beneficiaries, who prior to 2012 were known simply as Medicaid *recipients*,[42] has also been a deterrent to the widespread acceptance of this patient population among physicians, the degree to which has varied from state to state.[43] While Medicaid has at long last matured into a program to be reckoned with, it must yet contend with a new crop of regulatory, economic and social hurdles, and its success will depend on whether it is fluid enough to adapt to the needs of these rapidly changing times. ■

Endnotes

1 Originally Title 19 of the United States Code.

2 In its initial form, Part A of the Medicare Act provided coverage for inpatient hospital costs and other similar expenses, while Part B created a voluntary program for beneficiaries to insure against costs from physician and other specific outpatient services and supplies. *See* Pub. L. No. 89-97. In 1997, Congress

enacted the "Medicare Advantage" option for beneficiaries (*see* Pub. L. No. 105-33), sometimes referred to as "Part C" and previously known as "Medicare + Choice." In 2003, the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (sometimes referred to as "Part D") made even more changes to the Medicare program. *See* Pub. L. No. 108-173.

3 *See, e.g.,* Pub. L. 103-448, Pub. L. 104-226, Pub. L. 105-12, Pub. L. 105.33, Pub. L. 106-113, Pub. L. 106-169, Pub. L. 108-448, Pub. L. 109-91, Pub. L. 110-90, Pub. L. 111-3, Pub. L. 111-5, Pub. L. 111-148, Pub. L. 111-152, Pub. L. 111-309, Pub. L. 112-78.

4 *See* 42 U.S.C. § 1395ww.

5 *See* 77 FED. REG. 68892-01 (Nov. 16, 2012) (to be codified at 42 C.F.R. pts. 410, 414, 415, 421, 423, 425, 486, 495).

6 As of February 2012, Title 42 of the United States Code, Chapter 7 (Social Security), Subchapter XIX (Grants to States for Medical Assistance Programs) contains the primary federal statutes.

7 *See, e.g.,* Sandra Decker, *In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help*, 31:8 HEALTH AFFAIRS (Aug. 2012); David Orentlicher, *Rights to Healthcare in the United States: Inherently Unstable*, 38 AM. J.L. & MED. 326, 332 (2012); Jennifer Kincheloe, E. Richard Brown, *et al.*, *Can We Trust Population Surveys to County Medicaid Enrollees and the Uninsured?* 25 (4) HEALTH AFFAIRS 1163, 1164 (July/Aug. 2006) (noting that impact of stigma associated with Medicaid participation on the accuracy of surveys); WILLIAM JULIUS WILSON, THE TRULY DISADVANTAGED: THE INNER CITY, THE UNDERCLASS AND PUBLIC POLICY 119 (1987) (recognizing the perceived nexus between Medicaid coverage and services provided to welfare recipients).

8 42 U.S.C. § 1396d.

9 Medi-Cal is California's version of Medicaid. *See also* H.B. 2619 Reg. Sess. 2011-2012 (Kan. 2011) ("KanCare"); OKLA. STAT. tit. 63, § 5009.4 ("SoonerCare").

10 *See, e.g.,* Jacobus tenBroek, *California's New Medical Care Law and Program*, 46 CAL. L. REV. 558, 559 (1958).

11 *County of Sacramento v. Chambers*, 33 Cal. App. 142 (1917).

12 *Id.* at 147.

13 *Morris v. Williams*, 67 Cal. 2d. 733, 783 (1967).

14 *See, e.g.,* CAL. WELF. & INST. CODE § 14000 ("The purpose of this chapter is to afford to qualifying health care and related remedial or preventative services, including related social services which are necessary for those receiving health care under this chapter.").

15 Last Spring the Federal Government replaced the term "recipient" with "beneficiary" throughout the Code of Federal Regulations to describe those who receive assistance from Medicaid, because the previous term was considered "unflattering." *See* 42 C.F.R. Ch. IV; 42 C.F.R. §§ 400.200 through 400.203.

16 *See* STATE OF CAL., DEP'T OF HEALTH CARE SERVS., MEDI-CAL PROGRAM ENROLLMENT TOTALS FOR FISCAL YEAR 2010-11 (2011).

17 *See* CAL. WELF. & INST. CODE § 14105.98.

18 *See* CAL. WELF. & INST. CODE § 15166.12.

19 *See* CAL. WELF. & INST. CODE § 14166.23.

20 *See* CAL. WELF. & INST. CODE § 14085.5.

21 *See, e.g.,* CAL. WELF. & INST. CODE § 14169.31.

22 *See* CAL. WELF. & INST. CODE § 14166.20.

23 This list does not exhaust California's resources directed at the Medi-Cal population, nor does it include the numerous county and local programs that also target funding for the benefit of Medi-Cal beneficiaries. *See, e.g.,* CAL. REV. & TAX CODE § 30122(a)(3) (*the Tobacco Tax and Health Protection Act of 1988*, which provides "funding for medical and hospital care and treatment of patients who cannot afford to pay for those services, and for whom payment will not be made through any private coverage or by any program funded in whole by the Federal Government"); ALAMEDA COUNTY, CAL., ORDINANCE 2004-32 (imposing a transactions and use tax for the purpose of providing additional support for emergency medical, hospital inpatient, outpatient, and public health care, as well as other services).

24 *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

25 *Id.* at 2606-07.

26 *See id.* at 2665 (Scalia, Kennedy, Thomas and Alito, JJ, dissenting) ("Congress never dreamed that any State would refuse to go along with the expansion of Medicaid. Congress well understood that refusal was not a practical option.").

27 26 U.S.C. § 5000A(c)(3)(A).

28 *See* 26 U.S.C. § 4890H(c)(1). The payment amount for "large employers" (defined as those with an average of 50 full-time *employees, see id.* § 4890H(c)(2)(A)) does not apply to the first 30 employees, however. *Id.* § 4890H(c)(2)(D)(i).

29 *See* 77 FED. REG. 18310 (Mar. 27, 2012) (to be codified in 45 C.F.R. pts. 155, 156 and 157); CAL. HEALTH & SAFETY CODE § 1366.6 (California Health Benefit Exchange); *but see* Robert Pear and Abby Goodnough, *States Decline to Set Up Exchanges*

for Insurance, N.Y. TIMES, Nov. 16, 2012, *available at* http://www.nytimes.com/2012/11/17/us/states-decline-to-set-up-exchanges-for-insurance.html?_r=0.

30 *See* 45 C.F.R. §§ 156.500 (basis and scope of CO-OPs), 156.505 (definitions), 156.510 (eligibility), 156.515 (standards) and 156.520 (loan terms) (effective Feb. 13, 2012); *see also* CAL. HEALTH & SAFETY CODE §§ 1399.80 *et seq.* (effective Jan. 1, 2013); *but see* Sarah Kliff, *The Fiscal Cliff Cuts $1.9 Billion from Obamacare*, WASH. POST (Jan. 2, 2013), *available at* http://www.washingtonpost.com/blogs/wonkblog/wp/2013/01/02/the-fiscal-cliff-cuts-1-9-billion-from-obamacare-heres-how/.

31 42 U.S.C. § 1396d(a).

32 42 U.S.C. § 1396d(y).

33 *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2665 (2012).

34 *See* FED. REG. 66670 (Nov. 6, 2012) (to be codified in 77 C.F.R. pts. 438, 441 and 447).

35 *See id.* The following chart is contained within the Federal Register:

Provision Description	**Total Costs**	**Total Benefits**
Payments to Physicians for Primary Care Services	The overall economic impact of this final rule is an estimated $5.600 billion in CY 2013 and $5.745 billion in CY 2014 (in constant 2012 dollars). In CY 2013, the federal cost for Medicaid and CHIP is approximately $5.835 billion with $235 million in state savings. In CY 2014, the federal cost for Medicaid and CHIP is approximately $6.055 billion with $310 million in state savings. The associated impact of this final rule requiring states to reimburse specified physicians for vaccine administration at the lesser of the Medicare rate or the VFC regional maximum during CYs 2013 and 2014, is estimated at an additional $975 million in federal costs. Specifically, this reflects federal costs for CYs 2013 and 2014 of $495 million and $480 million, respectively.	The overall benefit of this rule is the expected increase in provider participation by primary care physicians resulting in better access to primary and preventive health services by Medicaid beneficiaries.

36 *See id.*; for California, *see* CAL. WELF. & INST. CODE § 14132.275(c)(3) (effective Sept. 22, 2012) ("'Dual eligible beneficiary' means an individual 21 years of age or older who is enrolled in the demonstration project under the capitated payment model.").

37 *See* sources cited *supra* note 7.

38 *See* FED. REG. 66670.

39 *See, e.g.*, Mary Agnes Carey, *"Doc Fix" in "Fiscal Cliff" Plan Cuts Medicare Hospital Payments*, KAISER HEALTH NEWS (Jan. 1, 2013, 5:53 PM), http://capsules.kaiserhealthnews.org/index.php/2013/01/doc-fix-in-senate-fiscal-cliff-plan-cuts-medicare-hospital-payments/. Had congress not averted the scheduled 26.5% payment reduction for physicians by this last minute compromise, an increase in the Medicaid rates to match Medicare, *see* FED. REG. 66670, would be a pyrrhic victory at best.

40 *See* 42 U.S.C. § 1395dd.

41 *See, e.g.*, Orentlicher, *supra* note 7 at 330; Abigail Moncrieff, *Payments to Medicaid Doctors: Interpreting the 'Equal Access"* Provision, 73 U. CHI. L. REV. 673 (2006); Sidney Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 AM. J.L. & MED. 191, 196 (1995).

42 *See supra* text accompanying note 15.

43 *See* sources cited *supra* note 7.