2015 Upcoming Events:

- **February 24-25, 2015**
  Sacramento Leadership Day—Sacramento, CA

- **April 30-May 2, 2015**
  Internal Medicine 2015-Boston, MA

- **May 20-21, 2015**
  Washington Leadership Day, Washington, DC

- **May 29-31, 2015**
  Western Healthcare Leadership Academy
  Hollywood, CA

- **To be Announced—2015 Board Review Course**

Inside this issue:

- Update from the President - Page 2
- CA-ACP Services Names President-Elect 2016 - Page 3
- CMA House of Delegates - Page 4-6
- Two-Midnight Rule - Page 7-9
- Early Career Physicians - Page 9
- American Lung Association - Page 10-11
- Covered California Update - Page 12-13
- Nat'l ACP Leadership Academy - Page 14
- Legislative Update - Page 15
Update from the President
... A look back at 2014

Members attending the 2014 CA-ACP Northern and Southern Chapter Scientific Meetings were on hand to hear President Amin’s update on the state of the California Services Chapter American College of Physicians.

In addition to CA-ACP’s vision for the future, Dr. Amin touched on the membership status for the four California chapters or “regions” to reflect an overall state increase of 3.10% over 2013. A trend that is anticipated to increase with ongoing outreach efforts.

The Covered California educational grant that was awarded to CA-ACP and three other health care partners to increase understanding of the state health benefit exchange was recently extended through March 31, 2015. This opportunity has been an added source of revenue and allowed us to expand our efforts on the advocacy front.

The CA-ACP Board approved acceptance of the FY 2015 budget last June and the fiscal position of the organization is stable. For year 2014 there was an increase in expenses for advocacy activities (Sacramento Leadership Days and retaining a Legislative Consultant); the year ended with a surplus of $38,582 and approximately $189,000 in reserves.

Board actions in 2014 included 1) acceptance of the 2015 budget; 2) approved contribution to the “Vote No on 46” MICRA Campaign; 3) Approved a bylaw amendment extending term limits for corporation officers from one to two years; and 4) approved recommendation notifying National ACP of strong objections to the Maintenance of Certification (MOC) movement until evidence confirms it is beneficial to the health care of our patients.

Dr. Amin also encouraged participation in the Advocates for Internal Medicine (AIM) program to further help ACP’s continued success on the state level and on Capitol Hill.

For many months we have been addressing the changes to the Maintenance of Certification program by the American Board of Internal Medicine (ABIM). Concerns were expressed by physicians nationwide regarding changes to aspects of the certification process. CA-ACP and National ACP listened to member concerns and worked with ABIM to communicate those concerns in efforts to effect an MOC program that physicians would find meaningful. The recent announcement by the ABIM Board admits they got it wrong and will be taking significant steps to develop a relevant, meaningful program that meets the needs of physicians. We appreciate ABIM’s pledge to “continue to listen to your concerns and evolve our program to ensure it embodies our shared values as internists”.

CA-ACP’s Vision for the Future

- Value-added membership
- Continue supporting our State and National advocacy efforts
- Ensure the continued fiscal stability of CA-ACP by maintaining a corporate reserve account invested conservatively.
CA Service Chapter ACP Names President-Elect—2016

The Nominations Committee of the California Services Chapter American College of Physicians recently announced Angie Chen, MD, FACP to the post of President-Elect 2016.

Dr. Chen attended the University of California, Davis School of Medicine and completed a year of Psychiatry at the California Pacific Medical Center in San Francisco before completing her Internal Medicine training at Santa Clara Valley Medical Center in San Jose, California in 2008. Dr. Chen is board certified by the American Board of Internal Medicine and a Diplomate of the American Board of Addiction Medicine. She is in private practice and a clinical instructor at Stanford School of Medicine.

Dr. Chen has served on the CA-ACP Board since 2009 and currently holds the position of Treasurer. She will serve a two-year term to succeed current President Alpesh Amin when his position ends in April 2016.
California ACP members participated at the 2014 California Medical Association’s House of Delegates held December 5-7, 2014 in San Diego, CA. ACP delegates included Chwen-Yuen (Angie) Chen, FACP, and Darin Latimore, FACP from Northern California ACP, Wayne Iverson and Paul Speckart, MACP, from Southern CA Region 3 ACP, Melvyn Sterling, MACP from Southern CA Region 2, Howard Williams, FACP (So CA Region 3 Governor), and myself.

There were many additional ACP members attending, including outgoing CMA President Richard Thorp, FACP, (Northern CA ACP), CMA Vice-Speaker of the HOD Lee Snook, FACP, (Northern CA ACP), Outgoing Chairman of the CMA Board of Trustees, Steve Larson, FACP, (Southern CA Region 2). CA-ACP Medical Practice and Quality Committee co-chairs, Art Lurvey, FACP, (Southern CA Region 1) and Roz Shorenstein, FACP (Northern CA-ACP) and Gordon Fung, FACP (Northern CA-ACP Governor) represented their county medical societies. Kathleen Doo, MD, (So CA Region 1) was a delegate representing the Resident and Fellow Section.

Several key issues were discussed, including the success in defeating Proposition 46. Future directions for CMA in 2015 will likely include support for a Tobacco product tax to help replace the cuts to the Medi-Cal program.

Downsizing of the CMA Board of Trustees was approved; the Board will continue to include one Specialty Delegation trustee, one Ethic Medical Organization Section trustee, and one Organized Medical Staff Section trustee.

Having one trustee from the Specialty Delegation was important for CA-ACP, as that trustee is selected by our ACP delegates as part of the CMA Specialty Societies Delegation.

CA-ACP authored 2 resolutions which were approved for forwarding to the AMA:

• Provide arbitration as an alternative dispute resolution process when IPAs disagree with insurers regarding medical necessity of a patient’s treatment.

• Notify CMS that a process is needed to fairly pay physicians for administration of covered injectable medications even when they are not purchased by the physician’s practise.

Additional actions by the CMA House of Delegates can be reviewed at the CMA web site: www.cmanet.org, on the House of Delegates tab.

CA-ACP works closely with CMA on state legislative issues. If you are interested in working with ACP and/or CMA on any legislative issues, please contact Ashley Ruby, CA-ACP Executive Director cal-acp@hotmail.com, your ACP Governor, or myself sesacp@aol.com. And, if you are not already a member, please join national ACP’s Advocates for Internal Medicine at http://capwiz.com/acponline/mlm/signup/ to participate in ACP’s national legislative program.
The House of Delegates convenes annually to debate and act on resolutions and reports dealing with myriad medical practice, public health and CMA governance issues.
2014 Session of the CMA House of Delegates

...Continued

CMA HOD Participants

Gordon Fung, MD, FACP and Northern CA ACP Governor

L-R: Susan Sprau, MD, MACP, CA-ACP Southern California Region 1 ACP and Jennifer Abraham

CMA Board of Trustee 2014-2015

Lee T. Snook, MD
Vice Speaker, House of Delegates, Sacramento
TWO-MIDNIGHT RULE
Medicare in Wonderland
Mac Sterling, MD and Melvyn Sterling, MD

"The time has come," the Walrus said,
"To talk of many things:
Of hospitals and OPOs
Of Medicare and dings
And why two midnights are the cause
Of patients selling rings."
— with apologies to Lewis Carroll

Medicare has formulated a new rule—the two-midnight rule—to reduce the money it pays to hospitals for diagnosis-related group (DRG) billing. This Alice in Wonderland gimmick allows the Centers for Medicare & Medical Services (CMS) to shift the cost of hospitalization from Medicare Part A—where the cost of care is almost entirely covered by the federal government—to Medicare Part B, where more of the cost is paid by the patient, unless they have insurance that covers “outpatient care.” Unfortunately, even with the Affordable Care Act, many patients cannot afford such insurance.

CMS currently mandates that patients be designated as “outpatient observation” (OPO) if their anticipated hospital stay is two midnights or less. These OPO patients are admitted to the hospital because they require health care services that are not available outside a hospital. They inhabit a hospital room; sleep in a hospital bed; are usually cared for by hospitalists, hospital nurses and other hospital staff; and are treated with hospital IV fluids and medications from the hospital pharmacy.

If the admitting physician fails to designate the patient as OPO and Medicare’s recovery audit contractor (RAC) decides the patient should have been OPO, the hospital is not paid for the care, and the patient pays the bill. To avoid being “RAC’d,” hospitals are now forced to employ specially trained staff to determine whether the patient is to be admitted as OPO vs. normal hospital status, wasting money that could be spent on patient care.

This absurd situation prompted physicians in the CMA House of Delegates to pass the following resolution in October 2013: “Resolved: That the California Medical Association request that the Centers for Medicare and Medicaid Services eliminate Outpatient Observation status for all patients who require care in hospitals.”

Medicare, we must acknowledge, is terminally underfunded. By 2017, its funding is predicted to be less than its costs. To stanch this hemorrhage of red ink, politicians and bureaucrats are trying to decrease Medicare’s costs before the program fails. Their central challenge is the same as the one articulated by Machiavelli during the Renaissance: “Do the ends justify the means?”

There is near universal agreement that we must maintain Medicare’s viability; but as with achieving any goal, some means are better than others. Simply put, there are two ways of balancing Medicare’s budget: our elected representatives can either increase Medicare taxes or decrease Medicare benefits.

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Two-Midnight Rule
Medicare in Wonderland

How often has an incumbent politician voted to raise a tax on the working public? Crickets chirp. But is the alternative of decreasing benefits any more politically palatable? Not really. Hence the contortions of Medicare’s decision to reclassify a less than two-midnight stay in the hospital as an “outpatient” benefit, thereby shifting costs to hospitals and to Medicare beneficiaries. Transparency, which begets an honest evaluation of the pros and cons of a change in Medicare policy, suffers when CMS administrators engage in doublespeak by calling nights spent and resources consumed inside a hospital an “outpatient” benefit.

**Seen from one perspective**, the DRG payment system—which was implemented in 1983 to limit Medicare expenses—is a victim of its own success. Under the system, Medicare pays a set amount for each diagnosis, thereby putting hospitals at risk for the cost of caring for patients whose expenses are greater than anticipated. Now CMS feels that the hospitalization process is “too efficient,” insofar as Medicare is paying a “full DRG” for stays that are shorter than anticipated. In a classic piece of bureaucratic flimflam, Medicare came up with the idea that a stay in the hospital spanning less than two midnights is actually just “observation,” rather than the provision of efficient inpatient hospital care.

The essential misrepresentation of the two-midnight rule is that a brief stay in a hospital is less resource-intensive than a longer stay. CMS staffers argue, without blushing, that hospital expenses are less per hour when a patient spends less than two midnights in a hospital, compared to hourly costs for a stay of more than two midnights. In fact, the opposite is often true.

Case in point: In the hospital where Dr. Mac Sterling practices as a hospitalist, the administration has created efficient diagnostic and treatment workflows. Several years ago, for example, it was virtually impossible to obtain an MRI on a weekend unless epidural abscess or hemorrhage was suspected. Now the MRI department is staffed to provide services seven days a week. This expanded schedule results in more timely diagnoses for many chief complaints, meaning that the hospital can discharge many patients before two midnights have passed. Doing this, however, is not cheap: the hospital must pay to have the MRI department staffed on weekends. Moreover, under the two-midnight rule, the hospital is penalized financially for providing patients with quicker diagnosis and treatment, as outpatient services are paid at a substantially lower—often dramatically lower—rate than inpatient services.

We disagree with the implicit assertion that brief stays in the hospital merely involve close observation. As noted above, resource-intensive diagnostic testing—which the outpatient setting is not set up to provide on an emergent basis—often occurs during short hospitalizations, allowing physicians to rule out dangerous conditions that would require further emergent interventions.

Consider the patient admitted for a transient ischemic attack (TIA). A well-equipped and well-run hospital can expect to complete a workup for this diagnosis before two midnights have passed. According to the two-midnight rule, however, this patient should be admitted OPO. But what happens when the TIA evolves into a cerebral infarct? Now the patient may need to stay in the hospital longer and be converted to inpatient status. Unfortunately for the patient, if they do not spend three midnights in the hospital after being changed to inpatient status, they will not qualify for the Medicare skilled nursing facility (SNF) benefit. Perversely, the result could be a newly hemiplegic patient who does not qualify for SNF benefits for physical, occupational or swallowing therapy. In addition, the patient will have to pay privately for any necessary SNF stay.

**The two-midnight rule** constitutes an example of political expediency. No Medicare benefits are being cut overtly, but CMS is widening a small stream of “observation stays” into a major river of hospitalized “outpatients.” As noted above, the result is to decrease Medicare A benefits and shift the costs onto hospitals and Medicare beneficiaries.
CMS has a multipronged approach to trimming the ballooning cost of Medicare. The two-midnight rule is one prong. Another is not paying for hospital readmission within 30 days when the patient has the same principal diagnosis as before. When a patient shows up in the emergency department with acute congestive heart failure 29 days after being discharged for a CHF admission, for example, the hospital is incentivized to admit the patient to OPO status, which costs the patient significantly more than an inpatient stay.

The two-midnight rule is a case of the tail of unrestrained health care costs wagging the dog of appropriate Medicare benefits. We submit that CMS should first comprehensively and logically determine the purpose of inpatient hospitalization before altering the definition of inpatient and outpatient. Providing efficient diagnosis and treatment should be among Medicare's top priorities. Do we really want to disincentivize the hospital system from developing processes for diagnosing and treating more quickly? Care in a hospital is much more expensive than true outpatient care. Making a shorter-than-expected hospital stay a criterion for decreasing a hospital’s reimbursement is a step in the wrong direction. Instead, let us, as a society, incentivize efficiency and quality of care.

Dr. Mac Sterling is a hospitalist at Alta Bates Hospital in Berkeley. Dr. Melvyn Sterling is an internist and palliative care physician in Orange County.

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REACHING OUT TO EARLY CAREER PHYSICIANS

Tiffany Leung, MD, MPH, FACP
ACP Northern CA Chapter Council

The CA Northern Chapter's Council of Early Career Physicians is seeking creative and motivated leaders like you! Being a leader in ACP as an early career physician offers unique opportunities to meet experienced members in all Internal Medicine career paths, engage in advocacy on state and national levels to shape health policy, access resources for continued learning in medicine and related disciplines, and so much more.

To apply for a leadership position, your ACP membership must be active and you must be an early career physician*. For application details, please visit our webpage for details http://www.acponline.org/about_acp/chapters/ca/cecp_leadership.htm and submit an application by February 20, 2015. If you’d like to nominate a colleague for leadership in the Council of Early Career Physicians, please contact us at canocecp@gmail.com.

*An Early Career Physician is defined as a physician member of ACP who is within sixteen (16) years of graduating from medical school and who is not a Medical Student or Resident/Fellow Member of ACP.

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Once a national leader in tobacco control efforts, progress is at a standstill in California as advances in statewide tobacco control policies have stagnated. These were the findings of the 13th annual American Lung Association State of Tobacco Control 2015 report released January 21, 2015.

The State of Tobacco Control 2015 report tracks yearly progress on key tobacco control policies at the federal and state levels, assigning grades based on whether laws are adequately protecting citizens from the enormous toll tobacco use takes on lives and the economy. This year’s report shows that while California earned a B for its smokefree air policies, the state received an F for its low tobacco taxes, an F for failing to sufficiently fund tobacco prevention and control programs, and a D for poor coverage of smoking cessation and treatment services.

Significantly, California’s weak position on tobacco prevention is due to the fact that the state has not increased its tobacco tax since 1999 and now ranks 33rd in the country at 87 cents per cigarette pack, far behind states like New York, Illinois, Texas, Florida, Oregon and Washington.

“Increasing the tobacco tax has been proven to reduce tobacco use,” says Gertz. “This is why the American Lung Association in California is standing with Save Lives California, a broad coalition dedicated to passing a lifesaving $2 per pack tobacco tax – either through the legislature or by ballot measure – by the end of 2016. By passing this measure, we will not only save the lives of people, we also will save California taxpayers billions in health care costs.”

Save Lives California will generate revenue to expand treatment services for Medi-Cal patients with tobacco-related and other illnesses, support existing statewide programs to prevent youth from using tobacco, stop illegal sales of tobacco, increase funding for medical research into new treatments and cures for deadly diseases such as cancer and lung disease, and restore California’s leadership in tobacco control efforts.

In conjunction with the national report, the American Lung Association in California released its State of Tobacco Control 2015 – California Local Grades report, which issues grades for all 482 cities and 58 counties in California on local tobacco control policies. To view the complete California report, visit www.lung.org/california

Despite the lack of action at the state level, the California Local Grades report found that numerous municipalities across the state have passed ordinances to protect their communities from the harmful effects of tobacco. The report shows that local policies prohibiting secondhand smoke in recreational settings now protect 80 percent of California’s total population, while more cities and counties are implementing policies that regulate electronic cigarettes.

EMERGING PRODUCT: ELECTRONIC CIGARETTES

Over the last decade, the tobacco industry has developed novel products targeting a new generation of tobacco users. One such product that has increased in use and advertising is electronic cigarettes, or e-cigarettes. According to the US Food and Drug Administration (FDA), an e-cigarette is a battery powered device that allows users to inhale an emission containing nicotine or other substances. The safety of these devices is still unknown, and initial studies have found carcinogens and toxic chemicals in the emissions produced by these products, including ingredients used to make antifreeze. The FDA has not found e-cigarettes to be safe and effective in helping smokers quit and has proposed regulations that will extend basic regulatory authority found in the Tobacco Control Act to e-cigarettes.
E-cigarettes are often available in flavors that may appeal to children and teens, including cotton candy, bubble gum, chocolate, strawberry and mint. There are almost 470 different brands of e-cigarettes on the market today, and e-cigarettes come in 7,700 different flavors. In fact, new evidence indicates that kids may be at-risk users of electronic cigarettes. Youth usage rates for electronic cigarettes have tripled, with a recent study reporting that more teens use electronic cigarettes than traditional, tobacco cigarettes or any other tobacco product.

In light of this emerging evidence, California cities and counties have passed policies that regulate the sale and use of electronic cigarettes. Dramatically increasing in 2014, 74 cities and counties recognized the harmful effects of these unregulated products in their communities, and implemented local policies to protect their residents.

For more information and to get involved in advocacy with the American Lung Association to reduce the burden of tobacco and e-cigarettes, please contact Vanessa Marvin, at 916-585-7671 or Vanessa.Marvin@lung.org.

![Electronic Cigarette Policies Implemented by Cities and Counties](image)

Figure 1 - American Lung Association in California, State of Tobacco Control 2015

Covered California Second Open Enrollment Period Resources
By: Catherine Direen, Independent Media Consultant

Health care reform dramatically decreased the number of uninsured Californians last year and the rate is expected to decline further in 2015. Family physicians and your staffs can support this effort by letting patients know they can contact Covered California to enroll in private plans or Medi-Cal, depending on their incomes.

Last year the state’s uninsured rate dropped by half, from 22 percent to 11 percent – the largest decrease among the nation’s six biggest states – as 1.2 million people enrolled in private plans and two million in Medi-Cal. Covered California expects to enroll an additional half-a-million people in private plans by the time 2015 open enrollment closes on February 15.

The key things family physicians and staff members need to know are where patients can enroll in coverage; where they can find help for related questions about immigration status, income and other issues; and how physicians can ensure they’re listed on (and only on) the correct health plan provider network directories.

For even more information about Covered California, you can download the free, CAFP-produced booklet, Covered California Basics: Resources, Tools and Information for You and Your Patients: http://familydocs.org/covered-california/tools-resources

Additional resource for patients

Fewer Latino consumers enrolled in coverage last year than expected; many cited concerns about mixed immigration status in their families as a reason why. Although only documented California residents qualify for coverage through the state health benefit exchange and Medi-Cal, questions about other family members may raise immigration questions. Covered California and the national exchange have pledged that information gathered in the enrollment process will not be used for any other purposes.

One good resource for clarifying issues and eligibility is Health Consumer Alliance (HCA), a partnership among legal aid organizations that provides free local assistance to individuals and families applying for or enrolled in Covered California or Medi-Cal. Patients can visit www.healthconsumer.org for contact information by county or call 888-804-3536.

HCA can help patients with:

• Complicated immigration questions such as documentation status, student visas, work visas, etc.

• Continuity of care requests and working with health insurance plans and California regulators (Dept. of Managed Health Care and Dept. of Insurance).

• Complex income questions such as how to calculate modified adjusted gross income, tax questions, and other income-related questions.

Questions about the difference between Medi-Cal and Covered California, the benefits of being Medi-Cal-eligible, and finding a physician.

... Continued on next page
Are you listed in the correct health plan directories?

California regulators found in a summer 2014 survey that Anthem Blue Cross and Blue Shield of California violated state law by misleading consumers about their provider networks through inaccurate provider directories. Each of the two companies’ error rates topped 25 percent, according to the California Department of Managed Health Care.

Family physicians can verify whether they’re listed on the right health plan panels (and not listed by mistake on the wrong panels) by checking each plan’s directory on the individual plans’ websites. This can be confusing because health plans have different physician networks for different coverage products and the products are named differently on the Covered California website, health plan cards and health plan websites.

Covered California’s *Provider Directory Reference Guide* links to the provider directory of each participating health plan and lists the various plan names used:


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ACP Leadership Academy

The ACP Leadership Academy provides members with training and resources to prepare you for leadership roles in your organization and in the greater healthcare environment.

Formal Leadership Training

In partnership the American Association for Physician Leadership, ACP offers live meetings, faculty-led online courses, and self-study modules to help fill gaps in your leadership knowledge and to build your CV – all while earning CME.

- ACP members receive the American Association for Physician Leadership member rate on all courses plus an additional 15% on selected courses.
- Earn ACP Certificates of Completion for each course you finish.
- Courses count toward becoming a Certified Physician Executive (CPE) or toward a master’s degree program in medical management from one of four prestigious universities.

Topics include strategic thinking, financial decision-making, managing physician performance, marketing, ethics, and more. Register today for the following instructor-led courses:

Managing Physician Performance  
Techniques of Financial Decision Making  
Three Faces of Quality

Learn more about all of the available courses offered through the ACP Leadership Academy.

Free ACP Webinars

As a supplement to the ACP Leadership Academy, the College offers free online webinars on leadership topics relevant to internal medicine. These webinars provide both an educational experience and a discussion forum so that you can learn, pose questions, and share ideas with leaders in the internal medicine field.

Registration is now open for the following upcoming webinar:

Title: Personal Financial Planning for Physicians  
Date/Time: March 17, 2015, 6:30 p.m. ET  
Cost: Free  
Speakers: Ralph L. Hibbs, Jr., MBA, CPA  
Chief Financial Officer  
American College of Physicians  
Register: [Sign up online now](#)
California Legislative Update
by Tom Riley, Legislative Consultant to CA-ACP

Feds eye massive transition from Medicare fee-for-service
The Obama Administration last week announced it will soon begin steering Medicare payments away from the traditional fee-for-service model, with half of all providers to be paid via “alternative” models by 2018. Those models – including Accountable Care Organizations (ACOs), patient-centered medical homes, bundled payments, and so on – are intended to better coordinate care and tie reimbursement to quality. Currently, 20 percent of Medicare payments flow through such models. U.S. Secretary of Health and Human Services Sylvia Burwell said that figure should climb to 30 percent in 2016. CA-ACP will be tracking and evaluating the new models for their impact on quality and access to Internal Medicine services.

Insurance Commissioner Issues Emergency Network Adequacy Regs:
Stemming from consumer complaints and allegations that several insurers have violated state law by misleading consumers about the size of their provider networks, State Insurance Commissioner Dave Jones issued emergency regulations intended to improve provider network adequacy in the state and to improve access to care. The regs would:
• Adhere to new standards for appointment wait times;
• Offer an adequate number of physicians, clinics and hospitals to patients who live in certain areas;
• Provide an accurate list of in-network providers;
• Provide out-of-network care options for the same price as in-network care when the number of in-network providers is insufficient; and Report to DOI information about their networks and any changes.

The emergency regulations complement 2014 legislation (SB 964 -- Hernandez, Chapter 573) that would increases oversight of health plans with respect to compliance with timely access and provider network adequacy standards. For more information about SB 964 and DOI’s emergency regulations, please go to: SB 964 (Hernandez, 2014) or DOI Emergency Regulations

Brown appoints Kent as DHCS chief
Jennifer Kent, former legislative affairs secretary to Gov. Arnold Schwarzenegger, has been appointed as Director of California’s Department of Health Care Services. Most recently the executive director of the association Local Health Plans of California, Kent will be in charge of the state’s gargantuan Medi-Cal program, which now covers 11 million people – almost a third of the state’s population – as well as roughly half the state’s children.

Tele-health Bill Reintroduction Likely:
Although language has not yet been completed, legislation by Assemblymember Bontes’ office is expected to be similar to last year’s AB 1310, also authored by Mr. Bonta, which would have clarified confusion under existing law about whether physicians outside of California may be reimbursed for Medi-Cal services. Advocates of AB 1310 argued that the Department of Health Care Services’ denial of claims for services provided to patients in California by California-licensed physicians providing tele-health services from outside California is a violation of existing law (which prohibits DHCS from limiting the type of setting where services are provided for purposes of payment under Medi-Cal covered tele-health services). CA-ACP will discuss possible support of the legislation once language is in print.