STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS

DIVISION OF WORKERS' COMPENSATION

PUBLIC HEARING

Thursday, April 11, 2024
Elihu Harris State Office Building
1515 Clay Street, 2nd Floor, Room 1
Oakland, California

GEORGE PARISOTTO
Moderator
Administrative Director

DR. RAYMOND MEISTER
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MAUREEN GRAY
Regulations Coordinator

DIR Official Reporters: Jennifer Ferguson and Linda Shryack

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(Time Noted: 11:02 a.m.)

ADMINISTRATIVE DIRECTOR PARISOTTO: Good morning. Thank you for coming to downtown Oakland this morning. It turns out we have a beautiful day today, which is really good to see. And, boy, you know, it's like I haven't attended one of these in quite a while. It seems like -- I mean, how many in-person hearings have we had in the last few years?

MS. GRAY: Not many.

ADMINISTRATIVE DIRECTOR PARISOTTO: Not many.

My name is George Parisotto. I'm the Administrative Director of the Division of Workers' Compensation. This is a public hearing for proposed revisions to the Official Medical Fee Schedule provisions that govern the maximum reasonable fees for pharmaceuticals dispensed to injured workers.

Under the California Labor Code, the fee schedule for pharmaceuticals is based upon the Medi-Cal pharmacy payment system. As you might have seen in our *Newsline*, the proposed regulations make revisions to the Physician Fee Schedule and Pharmaceutical Fee Schedule to adopt relevant Medi-Cal revisions and related provisions of the Labor Code. Medi-Cal implemented a revised payment system utilizing National Average Drug Acquisition Cost, Wholesale Acquisition Cost, Federal Upper Limit, and Maximum Allowable Ingredient Cost in the drug reimbursement formula. The new Medi-Cal methodology also revises the pharmacy dispensing fee value and structure by

updating the dispensing fee from $7.25 to a two-tier dispensing fee of $10.05 or $13.20, depending on the annual volume of pharmacy claims processed.

There are copies of the notice and regulations on the front desk. Please make sure you sign the sign-in sheet and indicate if you want to testify today.

Now I would like to introduce the other DWC staff here today. Maureen Gray on my far right is the Division's Regulations Coordinator. And I would like to thank her for arranging this meeting and getting everything together. She does a spectacular job.

MS. GRAY: Thank you.

ADMINISTRATIVE DIRECTOR PARISOTTO: To my immediate right is our Executive Medical Director Dr. Raymond Meister. To my immediate left is DWC's Chief Counsel Ted Richards. And to my far left is our attorney extraordinaire Jackie Schauer. Our hearing reporters today are Linda Shryack and Jennifer Ferguson. Thank you both for attending.

When you come up to testify, please give your card, if you have one, to Ms. Gray. All testimony given today will be taken down by our hearing reporters. If you have any written testimony you want to hand in, please also hand that to Ms. Gray.

If you wish to be notified of the final adoption or subsequent changes to the proposed regulations, please provide

your complete name, mailing address, and email address on our hearing registration attendance sheet located at the sign-in table. The final notice or notice of changed proposed regulations will be sent to everyone who requests such information.

I will call the names for those who have checked that they wanted to testify. I will also check to see if anyone new has decided to comment.

This hearing will continue as long as there are people present who want to testify but will close at 5:00 this afternoon. We will probably go straight through to 1:00 and then take a lunch break, if necessary. I'm not sure if we need to do that, but we will certainly do that if that happens. Written comments can be given to Maureen, if you have them with you, or will be accepted by fax, email, or delivery up until 5:00 at the Division's office on the 18th floor of this building.

The purpose of this hearing is to receive comments on the proposed amendments to the regulations, and we certainly welcome any comments you may have about them. We will not question, respond to, or discuss anyone's comments, although we may ask for clarification or ask you to elaborate further on the points you are presenting. All your comments that will be given here today and those submitted in writing will be considered in determining what revisions we make to the

regulations. Please restrict the subject of your comments to the regulations and to any suggestions you have for changing the proposed regulations, and we also please ask that you limit your comments to 30 seconds. Oh, I'm sorry. We usually have limits on our comments of three to five minutes, but since I see not many people have checked, you know, please feel free to go on as long as you think is necessary and relevant.

In terms of submitting written comments, you can submit written comments by fax, email, and probably not delivery, up until 11:59 p.m. today. So you have practically until midnight if you would like to get your written comments to us.

So, a reminder. Please make sure you have signed in, if you wish to speak, and that you have checked the box indicating that. And again, when you come up to give your testimony, please give Maureen, Ms. Gray, your card, if you have one, so that we can get the correct spelling of your name in the transcript. Please speak into the microphone, which I am going to hand to you, or I think Maureen will hand to you. And before starting your testimony, please identify yourself for the record.

And so, our first speaker today, or our first person who will be giving comments, Tracy Euler.

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TRACY EULER

MS. EULER: Good morning, everyone. My testimony probably

will be 30 seconds, just to stay in line with what you've asked. Hi, I'm Tracy Euler. I'm here on behalf of Health-e-Systems. Thank you so much for having me here today and for considering our written comments in addition to my -- today's in-person testimony.

To begin, we urge the Division to consider and strongly recommend extending the effective date of the new regulations from 90 days to six months. This would provide ample time for necessary system modifications, ensuring stakeholders are able to comply with the new rules more easily.

Additionally, we propose a simpler approach to the two-tier dispensing fee, advocating for a single dispense fee instead. This avoids unnecessary complexity and ensures fair compensation for pharmacists. Thank you.

ADMINISTRATIVE DIRECTOR PARISOTTO: Our next speaker is Brian Allen.

And if you can't hear me in the back, please let me know.

AUDIENCE MEMBER: I can hear you, George, it's all good.

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BRIAN ALLEN

MR. ALLEN: Thank you, Director Parisotto, and your team for allowing us to be here to comment. My name is Brian Allen, B-r-i-a-n A-l-l-e-n. I'm with Enlyte Pharmacy Solutions, formerly known as Mitchell Pharmacy Solutions. And I'm a recovering politician, so 30 seconds would be a real lift for

me, to stay that short. But I am the Vice President of Government Affairs for Mitchell, and we have -- we have talked a lot about Pharmacy Fee Schedule and the implications this might have, and I just want to just mention a few things.

First of all, thank you for your effort on getting the implementation done. I know it was a heavy lift for you guys to get to this point to allow this to move forward, and we appreciate all those efforts. It has not gone unnoticed. COVID didn't help, you know. So we've -- we have had a lot of interference getting to this point today.

We do have a concern with the reimbursement level. And I want to point that out because it's going to be a disruptor in the marketplace. We -- right now the current reimbursement under the 2019 fee schedule is low enough that a lot of companies won't come and do California-only business, because there's just not enough margin in it to make it work for a PBM. And so, this is going to be worse. So it's going to change how PBMs have to try -- have to bill for their services. You're basically -- these new reimbursement levels have a pass-through pricing model, it's what the pharmacies are paying for drugs, and they're going to want that. They're not going to accept lower reimbursement for that, and nor should they have to. They shouldn't have to dispense at a loss. We would never want that to happen. There is not any profit in there. There's no margin to pay for clinical services or administrative services.

So it's going to change a little bit about how we do business. In fact, it's going to change it a lot. We're going to have to go out and negotiate changes and reimbursement for all of our customers. So there is a lot of time and effort involved in that. And we're going to have to look at adding a fee, an administrative fee or a clinical services fee, to cover things like processing a bill, formulary adherence monitoring, checking for compensability, eligibility, opioid management, and a host of other services that PBMs provide in the marketplace for injured workers, to make sure they're getting the right care for the right reasons at the right time and at the right cost. So those are the things -- that's going to be a change in the marketplace. And I don't -- I don't want to disillusion anyone or -- or make anything too outlandish, but it's probably not going to result in any kind of a real savings in the pharmacy space because the margins are so thin now. It's just going to be an offset. We're just going to move from the reimbursement to the pharmacy plus an admin fee. And it's not going to probably see -- I mean you could see individual customers within that change, but for the most part it's going to be pretty flat for everybody. So we just need to be prepared for that.

And I think the other thing I want to comment on is the timing. And I'll just echo what Wendy said. I mean it was several years for you to implement the change. Us getting it

done in 90 is going to be -- we would have to have people working night and day to get that done. We're asking for 180 days, a six-month time frame to do the implementation. That would give us time to test all of our systems and make sure they are talking appropriately with you and we're getting information back and forth the way it's supposed to work. And it also gives us time to go out and renegotiate contracts and do the things we need to do on the admin fee.

We think the admin fee is something that the marketplace should determine. It's not something that's in the fee schedule now. I don't think it needs to be. It's a contractual relationship. And it's going to vary from customer to customer depending on the level and types of services they want. If someone wants a very basic bare-bones thing, the fee will be one thing. If they want some of the bells and whistles, it's going to be another thing. And so, we want to make sure that, you know, we have enough flexibility to make that work. So just consider that as you're thinking about changes.

And the other thing that we put in our written comments is just, unlike compounding, physician dispensing, we put a reminder in there about all that stuff still has to be pre-authorized before it's reimbursed. And if it's not pre-authorized, it shouldn't get paid for. And we want to make sure that that stays true, that we don't lose that. Because

that's been a very valuable tool to get outliers out of the system, and it's made a real difference. We have noticed the difference, and we would like to make sure that that process stays in place so that we can screen those before they're dispensed so that we're not getting unnecessarily expensive or unnecessary useless drugs being prescribed and dispensed to injured workers. Thank you.

ADMINISTRATIVE DIRECTOR PARISOTTO: Thank you.

I had to actually debate with somebody last week because they said they wanted me to do something in 90 days, and I said, Okay, three months, and they were like, No, 90 days. And I was just like, Well, okay.

Frank Juliano.

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FRANK JULIANO

MR. JULIANO: Hello, everyone. Thank you for having me here today. My name is Frank Juliano, and I'm providing comments on behalf of St. Mary's Managed Pharmacy Programs.

Since 1996, St. Mary's has operated as a repackaging pharmacy, supplying over 700,000 dispensed meds nationwide and over 80,000 in California per year. One of our biggest customers is Concentra Medical. Concentra has over 100 occ med centers in California, and in 2023 treated over 200,000 injured California workers. I, myself, am a pharmacist. And prior to working at St. Mary's, I had hands-on experience in retail at

CVS and, as such, I have hands-on knowledge of the dispensing process in both the pharmacy as well as in a clinic.

I am speaking today in opposition to the proposed changes to the fee schedule, specifically section 9789.40.5(f), which eliminates the dispensing fee for physician-dispensed medications. By removing this dispensing fee, you will effectively eliminate physician dispensing altogether for work comp in California. California's fee schedule is already based on the acquisition cost only of the medications being dispensed. The dispensing fee covers the additional costs incurred in the dispensing process. Without this fee, the cost to acquire and dispense a medication will exceed the fee schedule reimbursement. And this is true for both pharmacies and in physicians' offices. However, while the physician fee is being eliminated, the pharmacy fee is being increased.

In the Initial Statement of Reasoning, it was determined that the dispensing fee is not warranted when a physician dispenses to an injured worker. The reasoning is that the fee for doing so is included in the physician office visit fee, more specifically in the Evaluation and Management code, E&M code. As many may point out here today, that is not correct. The Evaluation and Management fee is paid to physicians for the -- for making the decision to prescribe the medication and then to follow the management of that prescribed medication as they go forth. But it's not a reimbursement for the dispensing

process.

So what makes up the dispensing process? In my written comments I put a chart that compares retail pharmacy dispensing process to physician offices. And you will see that the process is very similar. And the cost associated with that process is also very similar. Steps such as, you know, purchasing medications, running them through a dispensing software that prints a patient label, monographs, drug inserts, everything that's required for pharmacy, physicians do that as well, including PMP reporting when necessary. And one of the often misconceptions when it comes to this topic, physician dispensing and the dispensing fee compared to pharmacy, is the fact that physicians purchase medications that are prepackaged into unit-of-use dosage and in dosages that, you know, in California meet the requirements, seven days, within seven days of an initial injury. They don't actually count out the pills and put them into a bottle as the pharmacies do. Many people feel that, for that reason, the dispensing fee may not be warranted. But what I will say is there still is a cost. The cost is simply being incurred by the repackager as they send it down to the physician. The cost is still there, even though they're not counting, and everything else is the same.

I would also like to point out that late last year California signed into law Assembly Bill 1286, aimed at promoting patient safety when filling prescriptions at retail

pharmacies. In part, this bill arose from a survey conducted by the California Board of Pharmacy, showing that 91 percent of retail pharmacies reported insufficient staffing to ensure patient care, and 83 percent reported a lack of sufficient time to provide safe patient counseling. So what does this mean? This means that California pharmacies are struggling to keep up right now. By eliminating the physician dispensing fee for work comp clinics, these scripts will instead go to these pharmacies that are understaffed. And, to me, it's not clear on the driving reasons for doing this, when you have already controlled all possible variables surrounding prescription drug management.

In the ISOR, it suggests that physician dispensing may be influenced by financial incentives. I agree with this, and there have been studies that support this suggestion. But the influence is not the dispensing fee. The influence is businesses and providers finding loopholes in the reimbursement methodology, choosing medications not listed on the Medi-Cal schedule with exorbitant AWPs, essentially taking advantage of the system. But, with these proposed laws, and specifically the updating of the Medi-Cal database, these loopholes will be closed. And, again, we strongly support that decision.

California, first with the adoption of the Medi-Cal reimbursement, followed by the introduction of the MTUS formulary, treatment guidelines, and authorization

requirements, is leading the nation currently right now in terms of reducing and controlling physician dispensing costs for work comp. The results of these changes are documented in a study that was released by WCRI in March of 2023. And that study looked at pre-formulary and after the formulary was put in place. And what it showed is that prescription payments per claim, with physician-dispensed medications, decreased 53 percent, to around $21 per claim. Payments per claim with pharmacy-dispensed medications increased 12 percent, to $39 per claim. And, lastly, it showed that California's physician-dispensed cost per claim, again $21, is five times lower than the average for non-formulary states. So, again, I applaud you. You have done a great job in controlling physician dispensing and some of the bad outliers out there.

So in the face of these significant positive results, why the proposal to eliminate the dispensing fee for physicians? The only reason appears to eliminate physician dispensing altogether. But doing so will do nothing to reduce costs. And, instead, these prescriptions will be filled at a retail pharmacy, possibly understaffed. And according to the WCRI data, it shows that it will be more expensive. It will get even more expensive once the pharmacy dispensing fees are increased. Option two is the prescriptions don't get filled at all. Many studies have shown that 20 to 30 percent of prescriptions don't make it to the pharmacy. They don't get

filled. Not filling a prescription, noncompliance, can be directly related to prolonged claim duration and increased costs.

The California Labor Code governing the workers' comp fee schedules states that, "the rates or fees established shall be adequate to ensure a reasonable standard of service and care for injured employees." This proposal, we feel, will unnecessarily make it more difficult for injured workers to receive their medications. Therefore, we are proposing something simple. Simply, we recommend that you allow for the lower of the two dispensing fees being offered for pharmacies but for physicians as well. That's it. Thank you.

ADMINISTRATIVE DIRECTOR PARISOTTO: Thank you.

Tim Madden.

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TIM MADDEN

MR. MADDEN: Good morning. Tim Madden. Thank you very much for being here in person. It's great to see everybody and it's great to be back having a face-to-face conversation, not a Zoom face-to-face conversation. I'm here on behalf of Concentra, and we have over 100 occupational clinics here in California and also are the largest occ med provider in the nation. We appreciate the opportunity to make comments on the proposed regulations.

Concentra has strong concerns with the proposed change to

section 9789.40.5(f) that eliminates the dispensing fee paid when a drug is dispensed by a physician. It is Concentra's position that the professional dispensing fee should be maintained for physician-dispensed drugs and should follow the same requirements as for pharmacy-dispensed drugs as defined in section 9789.40.1 of the proposed amendment.

In the Initial Statement of Reasons it states, "Many of the tasks involved in dispensing a drug to a patient are already included in the physician's reimbursement." As mentioned with the previous speaker, we do not agree with this assessment. The Evaluation and Management codes fee for a patient encounter -- and the codes that we use are normally 99202 to 99215 -- only includes the work value associated with the management of the medication regarding the decision to prescribe. It does not address the cost and value of the actual medication dispensing.

In further support of our position that the value of the dispensing itself is not part of the Prescription Drug Management, the industry standard is that the E&M medical decision-making component is strictly intended for the physician to assess the patient's medication needs and determine the action to take, nothing more.

At the risk of repeating some of the comments that were made by the previous speaker, I thought I would add a couple specific aspects to Concentra's business. They do about 200

prescriptions on an annual basis for injured workers. And they included in their comment letter examples of two commonly prescribed drugs and the impact that the proposed regs would have on those. So looking at Cephalexin, which is an antibiotic, Concentra's cost is $7.49 for that. Under the new proposed fee schedule, that would go to -- the reimbursement would be $4.12. Whereas for a pharmacy, it would be anywhere from 14 to 17 dollars. So you can see, when you eliminate the dispensing fee, it throws it to a place where they're actually losing money as they dispense medications. For naproxen, which is an anti-inflammatory, Concentra's cost is $6.80. And under the proposed fee schedule, they would be reimbursed 90 cents for that. Once again looking at pharmacies, it would be anywhere from $10 to $14. So once again, when you take that dispensing fee out, it really turns the equation upside-down. And Concentra will be in a place where they most likely no longer dispense medications to injured workers.

So then the question comes back to -- or not the question, but the point comes back to what happens to that injured worker. And as mentioned before, the adherence when injured workers are required to go to the pharmacy to fill their prescription, it just changes, there is a drop-off. Studies have shown that. I'd be more than happy to provide those studies. And what happens to the injured worker when they don't get their antibiotic or they don't get their

anti-inflammatory, they don't start it right away, is that it delays care, it delays time for them to start healing, and it increases their time away from work.

Another aspect to keep in mind is pharmacies require payments for medications up front. Injured workers, particularly those newly injured without an approved workers' comp claim, may not be able to afford to pay for the medications or may feel like they should pay for the medications out of their own pocket. Concentra clinics will dispense the medications assuming risk that the claim may not be accepted. If the injured worker cannot afford to pay for medications out of pocket, they simply go to the emergency room, which leads to increased costs to the system and worse outcomes for the injured worker themself. In the aftermath of the COVID pandemic and the impact of staffing, California emergency rooms are already overcrowded, as I know you understand.

The reasons outlined above will lead to injured workers either delaying in taking their medications or not filling their prescription at all. This will result in prolonging of workers' injuries and further delay their return to work.

As mentioned, California, you all have done a great job at really going at some of the bad actors in the system in terms of taking advantage of physician dispensing, of repackaging and compounding. These regs do even more to close those loopholes,

as it was previously mentioned. From Concentra's perspective, we really believe the value that they provide for injured workers is to get them care as quickly as possible and get them on medications as quickly as possible, thus getting them back to work as quickly as possible. So we appreciate your time and your consideration of our comments.

ADMINISTRATIVE DIRECTOR PARISOTTO: Thank you.

Don Schinske.

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(Remainder of hearing reported by Linda Shryack.)

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DON SCHINSKE

MR. SCHINSKE: Thank you, all. I'm Don Schinske. I'm here on behalf of the Western Occupational and Environmental Medical Association. We're the regional component of the American College Foundational Environmental Medicine. Our docs work up and down the work comp system as primary treaters, UR docs, QME, company medical directors, you name it. You'll find one of our members somewhere in the system.

I guess I would like to align ourselves officially with the comments that have been made by my predecessors here, but frankly, we're here to beg for $7.25, is what it boils down to. I'm not going to stand here and claim that doctors are going to leave the system if they don't get the dispensing fee, because that's probably not the case. But, we do know they will stop

dispensing, and I think for a variety of reasons that winds up not being a very good idea. You know, the subjective insult to physicians and their judgments, and their ethics aside, it doesn't actually work out terribly well for injured workers when that happens.

Obviously, if you come in with a cut or a needle stick, and you can't get that first round of antibiotics dispensed by your physician, you go to the Rite Aid with your script. They don't have a case number opened for you, you have to come back tomorrow and stand in line again. Maybe you come back, maybe you don't. But in the worker's mind, not only are you not recovering as fast as you might, but you have entered into that type of mindset about workers' compensation. That is, there's a transaction that happens when you initially contact a system. Is this system working for me or is it working against me? Am I gonna have to fight this thing every step of the way? And I would argue that it doesn't take too many of those cases where someone doesn't get their antibiotic, where it starts going the other way, and they become one of those cases. How many of those does that take, 50 or 100 maybe across the State of California, before the savings from all those incremental $7 are more than offset by complex cases at the other end.

So I would just think about that a little bit and the worker's experience when they engage with the system and ask that the $7, and I'm not even asking for 10, 7.25 -- just keep

it there. Thank you.

ADMINISTRATIVE DIRECTOR PARISOTTO: Thank you.

Steve Cattolica.

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STEVE CATTOLICA

MR. CATTOLICA: Good morning, I think. Yeah, it's still morning. My name is Steve Cattolica.

I represent the California Neurology Society, the California Society of Physical Medicine and Rehabilitation as treating physicians, and our comments would align with the previous witnesses.

And so we're -- we don't see any value in eliminating a point of distribution by eliminating the physicians' dispensing fee. What it does, though, and this is actually the major point I'd like to make, is it more centralizes the distribution to -- through MPNs that are entities, that provide physician services and are contracted to provide all of those things through a single portal or a single method, and it puts those MPNs that are constructed that way into a position of actually making more money on this deal when the physicians don't, don't dispense, because they'll go through their in-house PBM, which means that they'll make more money. And all that does, again, is centralize the revenue system and enrich the MPN or the entities that provides physician services and eliminate an important distribution point from the perspective of compliance

with the treatment that's necessary for the injured workers. Thank you.

ADMINISTRATIVE DIRECTOR PARISOTTO: Well, believe it or not, I've come to the end of the list of the people who would testify, so I would like to ask if there's anyone else here who would like to add some comments?

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LISA ANNE HURT-FORSYTHE

MS. HURT-FORSYTHE: Good morning. My name is Lisa Anne Hurt-Forsythe, and I represent the American Association of Payers, Administrators and Networks, and have been around the California comp system since before the wheel and fire.

My comments are going to be an amalgamation of several of our PBM members and other affiliated network entities that belong to our Association, and some of these are comments that others have made with a little bit of a variation on a theme. And I'll be brief because we all want to go somewhere else.

The first is the six months for implementation is a must-have on our side. We just can't pull a rabbit out of a hat, and I think it was Ryan that said, it took you all a while to figure out how to do a pricing calculator. Feel our pain, is all I'm going to say about that.

Number two, sort of related to that is the bifurcated dispensing fee. If we want to make it easier, just have the one. Don't -- just, no -- very simple. It would be much

easier if it was a single dispensing fee. When we have that two-tiered type of pharmacy volume, it just makes it so much more convoluted and complicated from an implementation standpoint. We have to deal with uploading the file and trying to figure out what if somebody shifts from this category to that category. And there's a million different things associated with that that could be eliminated if we just make it uniform.

Also, with respect to the so-called unfinished compounds ingredient language, several of our members feel that that could be reworded and made in a way that's a little bit less convoluted and a little bit simpler. Drug ingredient costs could be tied to established benchmarks like WAG (phonetic), things that already exist in the system that our members are already affiliated with. It would definitely help with the implementation side of things and make the system a little bit simpler.

The other thing was with respect to, we would like to stress that noncompliant compounds and physician-dispensed medications should not be reimbursed with prior authorization, and there's three different flavors-of-the-month club with that. If we have a compound med. that didn't receive prior auth., we would like the regs. to specifically state that those will not be reimbursed. Physician-dispensed medications that did not receive prior authorization, although some of these

testifiers are saying maybe that will go away, and this will albeit my remarks, but if they did not receive prior auth., we would like those to also not be reimbursed.

And then the hybrid would be compounded medications that were dispensed by a doc that did not have a prior auth., would not be reimbursed.

So we would like to have specific language in the regulations that address those three scenarios.

And then related -- so my theme is simplification and make it a little bit easier. So my last remark would be with respect to the compounding fee. Just having one would be great, instead of 14 or however many are in there. Just, again, just making it simpler, easier for us to administer on the payor side, easier for all the stake holders to follow. Everybody knows what they're getting paid. It eliminates a lot of the friction in the system if we can make it a little bit simpler. That's all.

ADMINISTRATIVE DIRECTOR PARISOTTO: Is there anyone else here who would like to add comments, going once, twice? Well, there we go.

So if there's no one else here who's going to testify, this hearing is closed. The opportunity to file written comments will stay open until 5:00 -- I'm sorry, 11:59 tonight. Those comments should be delivered to the DWC office up on the 18th floor of this building; although, good luck doing that at

11:59.

Yes.

MALE SPEAKER: You'll take them electronically up until 11:59?

ADMINISTRATIVE DIRECTOR PARISOTTO: That is correct.

FEMALE SPEAKER: Unless your name is Steve.

ADMINISTRATIVE DIRECTOR PARISOTTO: So thank you for your attendance and the input you've given us. And I'd like to say it's been a pleasure to be here in Oakland for a public hearing on regulations, and I look forward to more, because unlike other Oakland-based traitors -- I'm sorry, entities, who have left our cities for Sacramento and Las Vegas, I think we will stay here. Thank you.

FEMALE SPEAKER: On behalf of Sacramento, thank you.

ADMINISTRATIVE DIRECTOR PARISOTTO: This hearing is closed.

(The proceedings concluded at 11:37 a.m.)

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REPORTER'S CERTIFICATE

I, Jennifer Ferguson, the undersigned Official Hearing Reporter for the State of California, Department of Industrial Relations, Division of Workers' Compensation, do hereby certify that the foregoing is a full, true, and correct transcript of the proceedings taken by me in shorthand (page 3, line 1, through page 20, line 8), and with the aid of audio backup recording, on the date and in the matter described on the first page thereof.

Signed and dated at San Francisco, California, this 16th day of April, 2024.

/s/ Jennifer Ferguson
Jennifer Ferguson
Official Hearing Reporter

R E P O R T E R ' S C E R T I F I C A T E

I, the undersigned Official Hearing Reporter for the State of California, Department of Industrial Relations, Division of Workers' Compensation, hereby certify that my portion (page 20, line 12, through page 26, line 17) of the foregoing matter is a full, true and correct transcript of the proceedings taken by me in shorthand, and with the aid of audio backup recording, on the date and in the matter described on the first page, thereof.

Dated: April 16, 2024

/s/ Linda Shryack
Linda Shryack
Official Hearing Reporter
Santa Rosa, California