Industry Collaboration Effort

2017 Annual Conference

Annual Legislative Update

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Overview

2017 Annual Conference

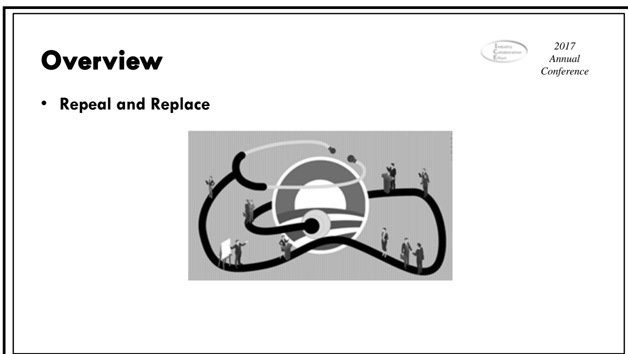
2017 Themes

- Repeal and Replace
- Single-Payer
- High Priced Drugs
- Mandates

Overview

2017 Annual Conference

- **Repeal and Replace**



Overview

2017 Annual Conference

- Single-Payer

Overview

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- High Priced Drugs

Overview

2017 Annual Conference

- Mandates

Legislation Overview

Defeated Mandates

- AB 1107 (Nazarian) Clinical Care Pathways
- AB 1110 (Burke) Children Eye Screening
- AB 1601 (Bloom) Hearing Aids for Children
- SB 172 (Portantino) Fertility Preservation
- SB 199 (Hernandez) California Health Care Cost, Quality, and Equity Atlas
- SB 221 (Wiener) Lipodystrophy Coverage

Legislation Overview

Two Year Bills

- AB 315 (Wood) PBM Registration
- AB 595 (Wood) Mergers and Acquisitions
- SB 399 (Portantino) Autism Expansion
- SB 538 (Monning) Hospital Contracts
- SB 562 (Lara/Atkins) Single-Payer

Legislation Overview

Two Year Bills

- AB 205 (Wood) Mega-Reg Implementation – MCP Requirements
- AB 340 (Arambula) EPSDT Trauma Screening
- AB 447 (Gray) Medi-Cal Glucose Monitors
- AB 1074 (Maienschein) Autism Provider Requirements
- AB 1316 (Quirk) Lead Testing
- AB 1534 (Nazarian) HIV Specialists
- SB 171 (Hernandez) Mega-Reg Implementation - Financing
- SB 223 (Atkins) Health Care Language Assistance Services

For Today

- SB 17 (Hernandez) Drug Price Transparency
- AB 205 (Wood) & SB 171 (Hernandez) Mega Reg
- SB 133 (Hernandez) Continuity of Care
- AB 1048 (Arambula) Opiates: Partial Fills

SB 17 (Hernandez)
Advance Notice of Drug Price Increases

BACKGROUND

- **Author:** Hon. Ed Hernandez, Chair of Senate Health Committee
- **Sponsors:** California Labor Federation, AFL-CIO & Health Access, California
- **Issue:** Advance Notice of Drug Price Increases / Report of Prescription Drug Costs

SB 17 (Hernandez)
Advance Notice of Drug Price Increases

Requirements

- Requires health plans that report rate information through the existing rate review process to also report information related to covered prescription drugs to the DMHC.
- Requires DMHC to compile the data into a report that demonstrates the overall impact of drug costs on health care premiums.
- The data in the DMHC report shall be aggregated and shall not reveal information specific to individual health plans.

SB 17 (Hernandez)
Advance Notice of Drug Price Increases

Requirements

- Requires drug manufacturers to notify specified state purchasers and health plans of an increase in the WAC of a prescription drug at least 60 days prior to the planned effective date.
- Applies to a prescription drug that has a WAC of more than $40 per course of treatment.
- Applies when the WAC is increasing more than 16 percent, including the proposed increase and the cumulative increases that occurred within the previous two calendar years prior to the current year.

SB 17 (Hernandez)
Advance Notice of Drug Price Increases

Requirements

- Requires drug manufacturers to notify OSHPD within 3 days of the commercial availability of a new prescription drug if the WAC exceeds the Medicare Part D specialty drug threshold.
- Provides that a purchaser that wishes to receive notice must register with OSHPD. OSHPD shall make available to manufacturers a list of registered purchasers.
- Requires drug manufacturers to provide other specified information to OSHPD related to the drug's price.

AB 205 (Wood)
Mega Reg

- **BACKGROUND**
- **Author:** Hon. Jim Wood, Chair of Assembly Health Committee
- **Sponsor:** Author
- **Issue:** Modernize California statutes to implement the Center for Medicaid and Medicare Services “Final Rule” regarding Medicaid managed care networks and beneficiary appeal rights.

AB 205 (Wood)
Mega Reg

- **Network Time and Distance**

- Effective July 1, 2018 establishes county time and distance standards for:
  - Primary Care
  - 15 new Specialists
  - Opioid treatment
  - Addiction Treatment other than Opioid Treatment
  - Outpatient Mental Health
- Sunsets the time and distance requirements in 2022 and requires information from the EQRO to be used to modify existing requirements.

AB 205 (Wood)
Final CMS MMC "Mega Reg"

Time and Distance Requirements

- **Primary care,** both adult and pediatrics: 10 miles or 30 minutes from the beneficiary's place of residence.
- **Hospitals:** 15 miles or 30 minutes from the beneficiary's place of residence.
- **Dental services** provided by a Medi-Cal managed care plan: 10 miles or 30 minutes from the beneficiary's place of residence.
- **Obstetrics and Gynecology Primary Care:** 10 miles or 30 minutes from the beneficiary's place of residence.
- **Pharmacy services:** 10 miles or 30 minutes from the beneficiary's place of residenc

AB 205 (Wood)
Final CMS MMC "Mega Reg"

- **Time and Distance Requirements**
- **Counties are divided up into four categories based on population density. For specialists, adult and pediatric, including obstetric and gynecology specialty care, as follows:**

- (A) **Up to 15 miles or 30 minutes** from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.
- (B) **Up to 30 miles or 60 minutes** from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

AB 205 (Wood)
Final CMS MMC "Mega Reg"

Time and Distance Requirements

- **For specialists, adult and pediatric, including obstetric and gynecology specialty care, cont'd:**
  - (C) **Up to 45 miles or 75 minutes** from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.
  - (D) **Up to 60 miles or 90 minutes** from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

AB 205 (Wood)
Final CMS MMC "Mega Reg"

Time and Distance Requirements

- **Opioid treatment time and distance standards:**
  - **A: Up to 15 miles or 30 minutes** from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.
  - **B: Up to 30 miles or 60 minutes** from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

AB 205 (Wood)
Final CMS MMC "Mega Reg"

Time and Distance Requirements

- **Opioid treatment time and distance standards cont'd:**
  - **C: Up to 45 miles or 75 minutes** from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.
  - **D: Up to 60 miles or 90 minutes** from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

AB 205 (Wood)
Final CMS MMC “Mega Reg”

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Time and Distance Requirements

- **For outpatient substance use disorder services other than opioid treatment programs, the county categories are:**
- **(i) Up to 15 miles or 30 minutes** from the beneficiary’s place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.
- **(ii) Up to 30 miles or 60 minutes** from the beneficiary’s place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.
- **(iii) Up to 60 miles or 90 minutes** from the beneficiary’s place of residence for the following counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Monterey, Mono, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba.

AB 205 (Wood)
Final CMS MMC “Mega Reg”

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Time and Distance Requirements

- **Outpatient Mental Health Time and Distance Requirements:**
- **Up to 15 miles or 30 minutes** from the beneficiary’s place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.
- **(B) Up to 30 miles or 60 minutes** from the beneficiary’s place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

AB 205 (Wood)
Final CMS MMC “Mega Reg”

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Time and Distance Requirements

- **Outpatient Mental Health Time and Distance Requirements Cont’d:**
- **(C) Up to 45 miles or 75 minutes** from the beneficiary’s place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.
- **(D) Up to 60 miles or 90 minutes** from the beneficiary’s place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne

AB 205 (Wood)
Final CMS MMC "Mega Reg"

Alternative Access Requirements

- Allows for alternative access requests to be filed with the annual demonstration of compliance with time and distance standards
- Allows for telecommunication to be used to fulfill network requirements and for alternative access
- Requires the alternative access request to be filed by specialty and zip code and provides DHCS with 90 days to approve or deny the request. If DHCS has questions regarding the information submitted, the 90 day clock stops.

AB 205 (Wood)
Final CMS MMC "Mega Reg"

"EQRO"

An External Quality Review Organization will review:

1. Number of requests for alternative access standards, the number approved, and the distance of the alternative standards.
2. Approximate number of beneficiaries impacted
3. Percentage of providers in the plan service area by provider and specialty type that are under a contract with a Medi-Cal managed care plan.
4. Reasons for approving or denying the alternative access standard
5. The process of ensuring out-of-network access
6. Timeframe for approval or denial of a request for alternative access standards by the department
7. Consumer complaints

AB 205 (Wood)
Final CMS MMC "Mega Reg"

Beneficiary Grievances

- Outlines the process and time frames for beneficiary grievances.
- Requires an enrollee to exhaust MCMC appeals prior to requesting a fair hearing.
- Extends the fair hearing request from 90 to 120 days.
  - Beneficiaries can request a hearing beyond the request of the 120-calendar day period. DSS will make that determination.
- Expedited hearings are permitted within three days, if the beneficiary's health condition requires.

SB 171 (Hernandez)
Final CMS MMC "Mega Reg"

BACKGROUND

- **Author:** Hon. Ed Hernandez, Chair of Senate Health Committee
- **Sponsor:** Author
- **Issue:** Updates California statute to implement the Center for Medicaid and Medicare Services Final Medicaid Rule regarding public hospital financing, medical loss ratio (MLR) for Medicaid managed care plans, and mental health parity.

SB 171 (Hernandez)
Final CMS MMC "Mega Reg"

Overview

- Establishes a process to replace the existing inter-governmental transfers to fund public hospitals with no risk to health plans
- Establishes a 85/15 medical loss ratio (MLR) for health plans. With calculations beginning in 2019
- Requires an MLR remittance begin in 2023 that will be calculated by contract rates
- Places Federal mental health parity requirements into state statute

SB 171 (Hernandez)
Final CMS MMC "Mega Reg"

Payments to Public Hospitals Background

- Public hospitals voluntarily provide the state match for the funding of public hospitals received from CMS
- The existing inter-governmental process used to fund public hospitals is no longer allowed under the Mega-Reg
- SB 171 seeks to ensure continued funding for public hospitals through directed payments from MCMC plans
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SB 171 (Hernandez)
Final CMS MMC "Mega Reg"

Payments to Public Hospitals

- Requires public hospitals to be placed into "classes" that are determined by DHCS in consultation with public hospitals
- Requires CMS to approve the payment methodology prior to it going into effect
- Creates a directed payment methodology and performance based quality incentive payments to replace the current inter-governmental transfers.

SB 171 (Hernandez)
Final CMS MMC "Mega Reg"

Medical Loss Ratio

- Beginning July 1, 2017 plans must calculate and report an MLR in accordance with the mega reg
- Beginning July 1, 2019 requires a MCMC to operate at an 85/15 MLR
- Requires for MCMC aggregate MLRs to be posted on the DHCS website
- Beginning July 1, 2023 requires a MCMC to pay a remittance when operating below an 85/15 MLR
- Requires the state to re-pay the federal share and for the state portion to be deposited into the Medically Underserved Account for Physicians

SB 171 (Hernandez)
Final CMS MMC "Mega Reg"

Mental Health Parity

- Requires require DHCS to ensure that all covered mental health benefits and substance use disorder benefits, are provided in compliance with the Mega Reg (which requires parity – essentially that access to mental health services is not more restrictive than medical or surgical services)
- Authorizes the DHCS to implement, interpret, or make specific this provision by means of all-county letters, plan letters, or plan or provider bulletins, and for the department to adopt regulations, by July 1, 2022

SB 133 (Hernandez)
Ind. Market Continuity of Care

BACKGROUND

- **Author:** Hon. Ed Hernandez, Chair of Senate Health Committee
- **Sponsor:** Author
- **Issue:** Expands continuity of care rights in individual market when a plan leaves a market or geographic area.

SB 133 (Hernandez)
Ind. Market Continuity of Care

Requirements

- Requires a health plan, at the request of a newly covered enrollee under an individual contract, to arrange for the completion of covered services by a nonparticipating provider if the newly covered enrollee's prior coverage was terminated for the following reasons:
  - The plan ceases to provide or arrange benefits for new plan contracts in the individual or group market, or all markets, in this state.
  - The plan withdraws a health benefit plan from the market.
  - A health benefit plan is withdrawn from any portion of a market.

SB 133 (Hernandez)
Ind. Market Continuity of Care

Requirements

- Requires health plans to provide notice that an enrollee may request completion of covered services in specified disclosure forms and evidence of coverages issued after January 1, 2018.
- Requires health plans to provide written copy of this information to contracting providers and providers groups and to enrollees upon request.

AB 1048 (Arambula)
Partial Opiate Fills

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BACKGROUND

- **Author:** Hon. Joaquin Arambula
- **Sponsor:** California Medical Association
- **Issue:** Opioids: Partial fill dispensing fees and prorated share of cost.

AB 1048 (Arambula)
Partial Opiate Fills

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Requirements

- Authorizes a pharmacist to dispense a Schedule II controlled substance as a partial fill if requested by the patient or the prescriber beginning July 1, 2018, as specified.
- Requires the full prescription to be dispensed not more than 30 days after the date in which the prescription was written.
- Authorizes a pharmacist to charge a professional dispensing fee to cover the actual supply and labor costs associated with dispensing each partial fill associated with the original prescription.

AB 1048 (Arambula)
Partial Opiate Fills

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Requirements

- Requires a health plan to prorate an enrollee or insured's cost sharing for a partial fill of an oral or solid dosage form of prescription drugs beginning January 1, 2019.
- Prohibits a prorated cost-sharing payment, or any portion thereof, made to a pharmacist for the dispensing of a partial fill from being considered an overpayment.
- Requires a health plan to prorate a copayment for a partial fill of a prescription.

2018 Legislative Preview

- Repeal and Replace?
- Single-Payer (SB 562)
- Universal Coverage Hearings
- Cost-Drivers
- Two-year bills (PBMs / Mergers)
- Gubernatorial and Legislative Elections

2018 Legislative Preview

- **Two Year Bills**
- SB 562 (Lara/Atkins) Single-Payer
- SB 399 (Portantino) Autism Expansion
- Monning Hospital Contracting
- Wood PBM regulation / Registration
- Mergers and Acquisitions

SB 538 (Monning)

Prohibits 6 provisions in health plan and hospital contracts:

1. Setting payment rates or other terms for nonparticipating affiliates of the hospital
2. Requiring the health plan to contract with one or more of the hospital's affiliates
3. Requiring third-party payors to confirm they are bound to a contract between a health plan and a hospital when they receive the benefits of that contract

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SB 538 (Monning)

- Supporters' Goal
- Opponents' Concerns

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SB 538 (Monning)

Prohibits 6 provisions in health plan and hospital contracts:

1. Setting payment rates or other terms for nonparticipating affiliates of the hospital
2. Requiring the health plan to contract with one or more of the hospital's affiliates
3. Requiring third-party payors to confirm they are bound to a contract between a health plan and a hospital when they receive the benefits of that contract

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SB 538 (Monning)

Prohibits 6 provisions in health plan and hospital contracts:

4. Requiring arbitration or alternative dispute resolution of anti-trust claims
5. Require the plan to impose the same cost-sharing obligations when the hospital is in-network but at a different cost-sharing tier than any other in-network hospital.
6. Require the health plan to keep provider payment rates confidential from self-funded payors.

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2018 DMHC Regulatory Agenda

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Overview:

- AB 72 Regulatory Implementation
- Restricted License Regulation
- Timely Access to Care
- RBO Regulation

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AB 72 Implementation

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Activity	Date
Stakeholder Meeting to Solicit Input on Standardized Average Contracted Rate Methodology and IDRP	June 26, 2017
Default Reimbursement Rate Filing Deadline and Effective Date	July 1, 2017
Independent Dispute Resolution Process (IDRP) Implemented	September 1, 2017
Stakeholder Meeting to Solicit Input on Proposed Standardized Average Contracted Rate Methodology	September 12, 2017
Formal Rulemaking Process	November 2017 – December 2018
Timely Access and Network Adequacy Report Filings	March 31, 2018
Regulations Effective	January 1, 2019
DMHC Report to the Legislature	January 1, 2019

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AB 72 Implementation

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- IDRP Process has implemented as of September
- Concerns over Patient PHI confidentiality
- Antitrust Concerns raised by CMA over exchange of rate data and decision publication
- Notation on the claims form that an advance consent form has been signed by the patient

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AB 72 Implementation

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- Standardized messaging code for EOBs to indicate whether the claim is subject to AB 72
- Clarification needed/best practice determined regarding Medical Services Index application
  - Use a 12-month rolling average?

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Restricted License Regulation

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- Codifies a long-standing process at the DMHC to issue LKK and RKK licenses to globally-capitated RBOs
- CAPG requested this regulation in 2014
- Recent filings by non-RBO entities prompted issuance to clarify the scope of the RKK

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Timely Access to Care

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- Feedback on MY 2017 Survey Process
  - Volume of phone calls
  - Multiple survey vendors
  - After hours calls

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Timely Access to Care

- Extraction Method
- Multi-Modal Survey – e-mail, phone, fax
- Coordination with SB 137 provider outreach
- Eliminate question about another practitioner in the office
- Remove provider group reporting requirement
- Report rates of compliance by network rather than product

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RBO Regulation

Coming in 2018 – an update to the SB 260 standards for RBOs

- Nine Changes:
  - All RBOs to report quarterly, regardless of size
  - Detailed financial statements similar to current plan submittals

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RBO Regulation

- Adoption of GAAP standards – summary financial statement
- Corrective Action Plan form modifications
- Shortening of CAP timeline
- Reporting by Sub-Delegated RBOs
- Limitations on use of guarantee agreements to 1 yr.

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RBO Regulation

- Tangible Net Equity (TNE) will be raised from $1 to 4% of annual FFS health care expenses
- Cash-to-claims ratio will exclude use of bad debt and receivables will drop from 60 days to 30 days
- DMHC may consider a one-year phase-in on these two items

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SB 137 Provider Directories

- California Provider Directory Collaborative process completed and IHA selected as the Host Entity for the statewide platform
- IHA will complete an RFI process for vendors over the next few months
- The portal could be operational by the end of 2018

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