2019 Annual Conference

Industry Collaboration Effort

2019 LEGISLATIVE SESSION

YEAR END REVIEW

Bill Barcellona
Exec. V.P. Government Affairs
Americas Physician Groups

Amber Kemp
V.P. Healthcare Coverage
California Hospital Association

Nick Louizos
V.P. Legislative Affairs
California Association of Health Plans

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OVERVIEW

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- New Administration
- Supermajority Legislature
- Single Payer
- Market Stabilization
- Coverage Expansion
- Executive Order

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STATE BUDGET

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- **Health California for All Commission** – Renamed the existing Council on Healthcare Delivery Systems to the Council for All Commission, and adjusts the responsibilities to evaluate options to transition to a single-payer health care financing system
- **Optional Benefits** – Restored the following optional Medi-Cal benefits: audiology, incontinence creams and washes, optical, podiatry, and speech therapy
- **Maternal Mental Health** – Extended Medi-Cal coverage from 60 days to 1 year for women with post-partum depression

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STATE BUDGET

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- **Undocumented Expansion** – Extended Medi-Cal Coverage to young adults up to age 26
- **Senior Penalty** – Increased the income eligibility for Medi-Cal's Aged and Disabled program up to 138% of the FPL
- **Pharmaceutical Executive Order** – Included budget trailer bill language to require DHCS to conduct Stakeholder meetings regarding the carve out of the pharmacy benefit from Medi-Cal managed care
- **MCO Tax** – Reauthorized the MCO Tax

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CALIF. INDIVIDUAL MANDATE SB 78

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- The California law imposes a tax penalty on any state resident who fails to maintain minimum essential coverage (MEC) for themselves and their dependents
- The tax penalty for failing to maintain MEC won't apply to certain individuals whose premium contribution for health coverage exceeds 8.3% of their household income for the taxable year
- The tax penalty is applied for each month without coverage, and is approximately one-twelfth of the state average premium for bronze level coverage for the applicable household size
- Beginning Jan. 1, 2020, California will provide additional premium subsidies to state residents who qualify for federal premium credits and earn between 400% and 600% of the FPL - $50,000 to $75,000 for a single individual and $103,000 to $155,000 for a family of four.

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FOCUS ON HEALTH PLAN BILLS – *NICK*

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- **AB 731 (Kalra) Rate Review**
- **AB 929 (Rivas) CA Health Benefit Exchange Data Collection**
- **AB 1642 (Wood) Medi-Cal: Alternative Access Sanctions**

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AB 731 RATE REVIEW - REQUIREMENTS

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- Expands rate review to large group health plan contracts, as specified.
- For large group products a health plan shall file the methodology, factors, or assumptions that would affect the rates paid by a large group.
- For large groups, the DMHC shall determine whether the methodology, factors, and assumptions used to determine rates are unreasonable or not justified no later than 60 days following receipt of all the information the department requires to make its determination.

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AB 731 RATE REVIEW - REQUIREMENTS

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- Allows a large group contract holder to apply to DMHC to review a rate change and determine if it is unreasonable or not justified, if the contract holder has more than 2,000 total enrollees; or, the plan failed to provide specified information.
- Requires the DMHC to use reasonable efforts to complete the review within 60 days of receiving all the information required to make a determination.
- Requires health plans and insurers to notify the contract holder if a large group contract or policy rate has been determined unreasonable by DMHC.
- If a plan fails to provide all the information required, the bill specifies that the rate is unjustified.

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AB 731 RATE REVIEW - REQUIREMENTS

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- Requires a health plan to disclose specified information in rate filings by geographic region for individual and group contracts, including the price paid for specified services compared to the price paid by the Medicare Program for the same services in each benefit category.
- A change on premium rates or changes in coverage stated in a large group health plan contract shall not become effective unless plan sends written notice at least 120 days before the contract renewal date.
- Changes the time frame for an existing public meeting requirement related to the large group market from annual to every even numbered year for DMHC (SB 546).
- Makes contracted rates between a health plan or health insurer, and a large group, confidential information exempt from disclosure under the California Public Records Act.

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AB 929 CHBE DATA COLLECTION – REQUIREMENTS

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- Establishes Covered California as a Health Oversight Agency and grants board authority to engage in oversight activities relating to the Exchange.
- Requires QHPs to report to Covered California information on cost reduction efforts, quality improvements, or disparity reductions.
- Covered California is required to publicly report these measures by QHP (on and off exchange – individual and small only).
- Plans would be required to report:
  - Enrollee data (demographic, coverage, premium, product, network, and benefit)
  - Encounter data
  - Quality measures
  - Performance improvement strategies
  - Payment methods (including contracted rates)

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AB 1642 MEDI-CAL - BACKGROUND

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- **Author:** Jim Wood, Chair of Assembly Health Committee
- **Sponsors:** Author Sponsored
- **Issue:** Medi-Cal Accessibility and DHCs Sanction Authority

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AB 1642 MEDI-CAL – REQUIREMENTS - OVERVIEW

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Makes a number of changes to the Medi-Cal managed care:

- Time and distance standards.
- Reporting in order to improve the delivery and utilization of services in the Medi-Cal program.
- DHCS existing administrative and financial sanction and contract termination authority of prepaid health plans. Instead, this bill requires those authorities, as specified, to apply to any entity that contracts with DHCS for the delivery of health care services, including Medi-Cal managed care plans (MCPs), mental health plans, Drug Medi-Cal services providers, and others.

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AB 1642 MEDI-CAL – REQUIREMENTS – ALTERNATIVE ACCESS

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- Beginning July 1, 2020, requires a Medi-Cal MCP requesting an alternative access standard for time and distance to include, a description of how the Medi-Cal MCP intends to arrange for beneficiaries to access covered services if the health care provider is located outside of the time and distance standards.
- Beginning July 1, 2020, demonstrate annually in their reports on compliance with the time and distance and appointment time standards and how the MCPS arranged for the delivery of covered services outside of the time and distance standards
- Requires Medi-Cal MCPs annually report compliance with the time and distance standards to measure compliance separately for adult and pediatric services for primary care, behavioral health, and core specialist services.
- Requires DHCS to include in their evaluation of an alternative access standard request to evaluate and determine whether the resulting time and distance is reasonable to expect a beneficiary to travel to receive care.

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AB 1642 MEDI-CAL – REQUIREMENTS – ALTERNATIVE ACCESS CONT'D

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Requires MCP, to assist an enrollee who must travel farther with obtaining an appointment with an appropriate out-of-network provider within the existing time and distance and appointment time standards, by doing the following:

- Make its best effort to establish a member-specific case agreement with an appropriate specialist provider
- Arrange for an appointment with a specialist within the Medi-Cal MCP's network and within the time and distance standards

Exempts the Medi-Cal MCP from assisting the beneficiary to obtain an appointment if there is not a specialist provider within the applicable time and distance standard **or** the Medi-Cal managed has attempted to establish a member-specific case agreement for the enrollee and the provider refused to enter into the agreement.

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AB 1642 MEDI-CAL – REQUIREMENTS – ALTERNATIVE ACCESS CONT'D

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- Requires a Medi-Cal MCP that has received approval for an alternative access standard to inform its members of the approved alternative access standards in a manner and timeframe determined by DHCS.
- Requires the EQRO to include, as part of the review of a Medi-Cal MCP and its time and distance standards, in addition to the requirements under existing law, for any approved alternative access standards, whether a provider was not located within the requested ZIP code or the Medi-Cal MCP was unable to enter into a contract with a provider in the requested ZIP code

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AB 1642 MEDI-CAL – REQUIREMENTS – SANCTIONS

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- Sanction Categories:
  - Failure to comply with Medi-Cal contract or state and federal laws and/or regulations
  - Defines good cause to include any finding where the health plan has failed to provide health care services, discriminated against and enrollee, or reason specified in the bill.

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AB 1642 MEDI-CAL – REQUIREMENTS – PENALTIES

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- Authorizes the Director, in lieu of terminating the contract, to require or impose a plan of correction and to issue one or more sanctions for noncompliance or good cause as specified in the bill
- Requires each beneficiary impacted by a violation to constitute a separate civil monetary penalty. Authorizes the Director to assess a separate civil monetary penalty for each day the contractor fails to correct an identified deficiency
- Requires the Director to consider specified nonexclusive factors when imposing civil monetary penalties

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AB 1642 MEDI-CAL – REQUIREMENTS – PENALTIES

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Penalties – Plan Activities

- Temporarily or permanently suspend enrollment and marketing activities;
- Require the contractor to suspend or terminate contractor personnel or subcontractors;
- Suspend default enrollment of enrollees who do not select a contractor for the delivery of health care services

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CHA LEGISLATIVE HIGHLIGHTS - *AMBER*

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Hospital Rate Regulation (AB 1611)

- Halted momentum on bill that would have banned surprise billing for patients (a measure that hospitals support), but also included a harmful provision that would have set rates for insurance companies to pay hospitals for out-of-network emergency care. This bill will resurface in 2020, and CHA will continue to oppose rate regulation while supporting patient billing protections.

Workers' Compensation Claims (SB 567)

- Defeated a bill that would have given workers' compensation benefits to hospital employees with certain illnesses and injuries — including cancer, asthma, musculoskeletal injuries, and others — unless the hospital could demonstrate the employee did not contract the illness or injury at work.

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CHA LEGISLATIVE HIGHLIGHTS

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Nurse Staffing Ratio Penalties (SB 227)

- Requires the California Department of Public Health (CDPH) to impose administrative penalties of $15,000 or $30,000 for violations of nurse-to-patient staffing ratios.
- Provides hospitals with ability to avoid penalties if they can demonstrate the violation was due to "unpredictable" and "uncontrollable" circumstances, and prompt efforts were made to maintain required staffing level; and if, in making those efforts, the hospital immediately utilized its on-call list of nurses and the charge nurse.

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CHA LEGISLATIVE HIGHLIGHTS

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Hospital Seismic Safety (SB 758)

- Would offer relief from the state's outdated and stringent 2030 hospital seismic standards. At CHA's request, this bill has been extended into 2020 to fine-tune language. This will help ensure the provision of uninterrupted care following a disaster and will help assure wary legislators that the bill enhances hospitals' disaster response approach.

Independent Contractors (AB 5)

- Codifies and expands the *Dynamex* decision, which adopted an "ABC" test for determining independent contractor status. Substantially limits the use of independent contractors, including health care professionals. Also adopts a limited business-to-business provision that could adversely affect health care staffing agreements and contracts.

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CHA LEGISLATIVE HIGHLIGHTS

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Community Benefits Reporting (AB 204)

- Secured important amendments to bill that would require hospitals to report community benefits at the hospital – rather than system – level. The bill no longer: includes a percentage of Medicare reimbursement for the definition of charity care; limits reportable community benefits programs; or requires new regulations.

Hospital Suppliers' Diversity (AB 962)

- Secured important amendments to new mandate that hospitals submit reports on the diversity of their suppliers. The amendments delay implementation of the bill until July 2021 and permit systems to report at the system-wide level rather than the individual hospital level. The bill remains problematic because hospitals will only be allowed to include suppliers with more than half of their employees in California, ignoring the purchasing patterns of multi-state systems and hospitals that work with national group purchasing organizations.

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CHA LEGISLATIVE HIGHLIGHTS

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DMHC Licensure Exemption (SB 714)

- Sponsored bill to clarify the process to receive an exemption from the Department of Managed Health Care's Knox-Keene licensure regulation and presumptively exempt particularly low-risk payment arrangements.

Health Care Coverage During Disasters (SB 382)

- Secured passage of a bill that would ensure hospitals are reimbursed for Medi-Cal managed care beneficiaries' extended stays when no post-acute facilities are available following a declared emergency. Bill vetoed by Governor.

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APG KEY LEGISLATION - *BILL*

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- Employee v. Independent Contractors
- Coverage Bills
- Licensure Bills
- Vaccination Exemptions

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AB 5 (GONZALEZ) INDEPENDENT CONTRACTORS: *DYNAMEX DECISION*

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- California Supreme Court issued in *Dynamex Operations West v. Superior Court* a decision on 4/30/18 significantly changing the way individuals can be considered "**independent contractors**" under California law.
  - Prior to *Dynamex* "independent contractor" status was determined by the *Borello* test.
- Under *Dynamex* independent contractor status will be determined by the "ABC" test.
- Under the ABC test, employer must prove ALL of the following in order for an individual to be considered an "independent contractor;"
  - The individual is **free from the control and direction of the hiring entity** in connection with the performance of the work, both under the contract for the performance and in fact;
  - The individual performs work that is **outside the usual course of the hiring entity's business**; and
  - The individual is **customarily engaged in an independently established trade,** occupation, or business of the same nature as the work performed.

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AB 5 (GONZALEZ) INDEPENDENT CONTRACTORS - EXEMPTIONS

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"The individual performs work that is **outside the usual course of the hiring entity's business.**"

A professional services exemption was drafted into the bill to accommodate physicians, lawyers, accountants, dentists, etc.

But not nurses, NPs, and PAs

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PROFESSIONAL SERVICES EXEMPTION

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- **"Professional services"** to be exempt requires employers to comply with a list of about a dozen factors that will be problematic for employers to satisfy. These factors include:
- 1) the business service provider is "free from the control and direction" of the contracting business entity;
- 2) the business service provider is "providing services directly to the contracting business rather than to customers of the contracting business;"
- 3) the service provider is customarily engaged in an "independently established business of the same nature as that involved in the work performed"; and
- 5) the service provider can "set its own hours and location of work."

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AB 5 IS NOT RESOLVED YET…

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- So while "Physicians" are specifically excluded, the remaining problem of other health professionals remained open due to the ongoing Kaiser Permanente labor dispute
- "Professional services" have the 12 factors that have to be made to meet the definition. But the factors make it impossible to comply with in the H.C setting. Eg. The second factor is "providing services directly to the contracting business rather than to **customers**".. obviously doesn't fit in the H/C setting since patients aren't "customers". But this was intentional because of the Kaiser stale mate.
- Now that the dispute is resolved we could see legislation to fix that issue in 2020
- Sectors of gig economy preparing a ballot initiative.
- We will see multiple pieces of legislation for the next few years on issue of **independent contractor** status in California.
- Likely litigation in this area.

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HEALTH CARE COVERAGE

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- AB 290 – Third Party Payments by Dialysis Companies
- AB 744 – Telehealth provider payments
- SB 600 – Fertility Preservation coverage mandate

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LICENSURE

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- SB 464 – Implicit Bias Training for maternal mortality
- SB 697 – Creates PA supervision agreement with flexibility allowing multiple physicians to supervise, eliminates chart review & allows for customized oversight by agreement

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VACCINATION EXEMPTIONS SB 276 AND SB 714

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- SB 277 previously established stricter rules around school admission requirements on immunizations, but some physicians were developing "exemption mill" practices
- Senator Richard Pan, MD brought legislation to dramatically increase the oversight of physician exemptions, under SB 276
- Pandemonium ensued…an unprecedented level of civil disobedience
- The DHCS Director lost her job over a social media posting
- The bill, along with SB 714, was passed and then signed by the Governor
- The Anti-Vaxxer movement has found a voice

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REGULATORY DEVELOPMENTS

DMHC and DHCS

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DMHC

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- Timely access to care
- Out-of-pocket cost tracking
- Provider Directory update
- RBO solvency implements
- General Licensure update

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DHCS

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Cal-AIM Waiver Renewal Process:

- Combines existing MMC waivers and spas
- Transitions CalMedi-Connect to statewide DSNP plan requirement in all counties
- Embeds several care coordination pilots into standard care delivery

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2020 FORECAST

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2020 PREVIEW – TWO YEAR BILLS

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- **AB 648 (Nazarian) Wellness programs: Oppose –** Prohibits a health plan from offering an incentive to an enrollee based on adherence to a wellness program. The bill would establish and impose various requirements related to wellness programs. *Assembly Appropriations*
  AB 1174 (Wood) Anesthesia Contracts: Oppose – Requires plans to report contract terminations or expirations with anesthesiologists to the Department of Managed Health Care. Allows for health plans to be fined if they do not have and maintain contracts with anesthesiologists as specified. *Assembly Appropriations*
  AB 1611 (Chui) Emergency Services Balanced Billing: Support if Amended – Prohibits an enrollee receiving ER services from an out-of-network hospital from paying more than the same cost sharing that the enrollee would pay for the same covered services received from a contracting hospital. Sets a default payment rate for the out-of-network hospital. *Senate Health Committee*

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2020 PREVIEW – ISSUES

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- **Presidential Election Year**
- **Single Payer/Medicare for All**
- **Healthy California for All Commission (Single-Payer)**
- **Health Care Cost, Quality, and Equity Data Atlas (aka – APCD)**
- **Pharmacy Issues**
- **Privacy Issues**

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THANK YOU!

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