ANNUAL LEGISLATIVE BRIEFING

2020 Annual Conference

Industry Collaboration Effort

Bill Barcellona – E.V.P. Government Affairs

Dietmar Grellmann – Sr. V.P. Policy

Nick Louizos – V.P. Legislative Affairs

2020 THEMES

2020 Annual Conference

Industry Collaboration Effort

- COVID – 19
- Economy / State Budget
- Provider Solvency
- Mental Health
- Housing
- Homelessness

IMPACT OF COVID-19

- General Uncertainty
- Revised Timelines
- Fewer Committee Hearings
- Fewer Bills
- Public Participation Impact
  - Dial-in / Video Conferencing Testimony
- Virtual Lobbying

ADVOCACY IN THE PANDEMIC ERA

2020 Annual Conference

Industry Collaboration Effort

Winner: Best mask design at a public hearing

BILLS ENACTED IN 2020

2020 Annual Conference

Industry Collaboration Effort

25 new health laws

3 health bills vetoed

BILLS FAILING PASSAGE

AB 4 (Arambula) Medi-Cal: Eligibility

AB 648 (Nazarian) Wellness programs

AB 1611 (Chiu) Emergency hospital service costs

AB 1904 (Boerner-Horvath) Physical Therapy Coverage

AB 1943 (Grayson) Insulin Affordability

AB 1973 (Kamlager) Abortion: cost sharing

AB 1986 (Gipson) Colorectal Cancer Screening

AB 2144 (Arambula) Step Therapy

AB 2203 (Nazarian) Insulin cost-sharing cap

AB 2204 (Arambula) Sexually Transmitted Disease

AB 2242 (Levine) Mental Health Services

AB 2348 (Wood) Pharmacy Benefit Managers

AB 2360 (Maienschein) Maternal Mental Health

AB 2625 (Boerner-Horvath) Emergency transportation

AB 2640 (Gonzalez) Genetic Biomarker Testing

AB 2781 (Wicks) Infertility Treatment

AB 2817 (Wood) Office of Health Care Affordability

AB 2984 (Daly) Prescription Drug Prices

SB 29 (Durazo) Medi-Cal: Eligibility

SB 65 (Pan) Financial assistance

SB 854 (Beall) Substance use disorders

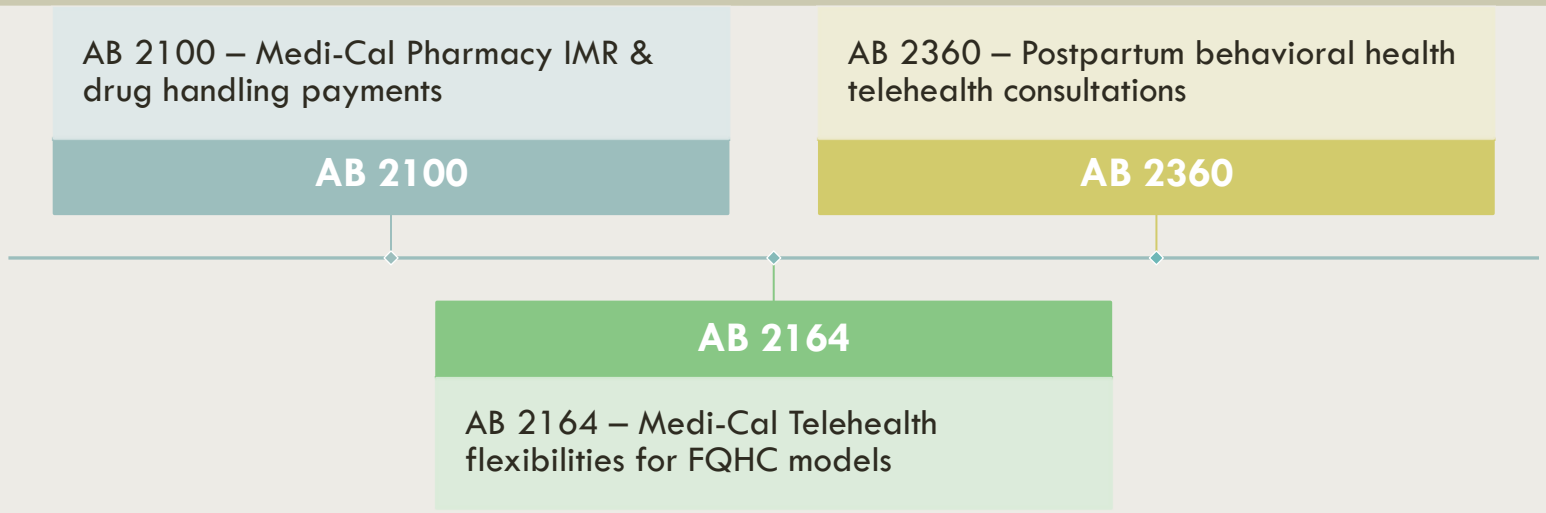
SB 936 (Pan) MCMC plans: contract procurement

SB 1033 (Pan) Utilization review criteria

BILLS VETOED BY THE GOVERNOR

2020 Annual Conference

Industry Collaboration Effort



The Governor's primary reasons included a preference to handle Medi-Cal policy through the state budget process.

AB 80 (BUDGET TRAILER BILL)

Healthcare Payments Database Program

- Requires OSHPD to establish the Health Care Payments Data Program to implement and administer the Health Care Payments Data System (HPD).

- Initial mandatory submitters include full service and specialized health plans and insurers with at least 50,000 covered lives in Commercial, Medicare, Medicaid and Individual markets

AB 80 DATABASE REQUIREMENTS

- Submit claims, encounter, pharmacy, enrollment, and provider information using a standardized data format. Mandatory submitters will also be required to submit other payment information(i.e. alternative payments) to OSHPD in a standard format.
- Requires OSHPD to produce publicly available information, including data products, summaries, analyses, studies, and other reports. Includes provisions on access to non-public data sets.
- OSHPD to submit a report to the Legislature, on or before March 1, 2024, that includes claims data reported by mandatory and voluntary submitters.

AB 80 GOVERNANCE

2020 Annual Conference

Industry Collaboration Effort

- Establish an advisory committee to assist and advise the director of the office in formulating program policies regarding data collection, management, use, and access, and development of public information to meet the goals of the program.

- Establish a data release committee to make recommendations about applications requesting access to non-public data sets.

AB 80 IMPLEMENTATION

2020 Annual Conference

Industry Collaboration Effort

- Data standardization
- Coordinate data submissions with contracted entities (ex. PBM, claims processing vendors, etc.)
- Initial data submission = 3 years' worth of data
- Establish regularly-scheduled data submissions to OSHPD
- Data quality, submission, and validation requirements
- Participation on OSHPD's Data Submitter Workgroup

SB 855 (WIENER)

Cosponsors:

The Kennedy Forum, Steinberg Institute

***Issue*:**

Coverage for services to treat mental health & substance use disorders

SB 855 REQUIREMENTS

- Repeals and replaces the California Mental Health Parity Law.
- Defines medically necessary treatment of a mental health or substance use disorder.
- Prohibits plans from limiting covered benefits on the basis that services could or should be covered by a public entitlement program or school-based services.
- Requires plans to apply specified clinical criteria and guidelines in conducting utilization review of covered services and benefits and would prohibit the plan applying different, additional, or conflicting criteria than the criteria and guidelines in the specified source.
- Expressly allows regulators to assess administrative penalties for noncompliance with aspects of the new law.

SB 855 ELEMENTS

This bill address the findings of March 2019 major federal court ruling. In *Wit v. United Behavioral Health* (UBH), the U.S. District Court for the Northern District of California ruled that, over a seven-year period, UBH used flawed medical necessity criteria to wrongly deny insurance claims for over 50,000 patients, including children and adolescents, seeking mental health and addiction treatment. The federal court held that UBH's internally-developed guidelines for evaluating medical necessity were pervasively flawed, inconsistent with generally accepted standards of behavioral health care, and were inappropriately influenced by a financial incentive to reduce costs, including a desire to "mitigate" the effects of the Federal Parity Act.

SB 855 IMPLEMENTATION

- The bill becomes effective on January 1, 2021 and affects every policy and plan that is issued, amended or renewed on or after that date
- DMHC will convene several stakeholder meetings in early 2021 to inform the development of regulations
- Implementing regulations will be issued prior to the end of 2021

SB 855 ELEMENTS

Defines **"medically necessary treatment of mental health or substance use disorder"** as a service or product addressing the specific needs of that patient, for the purposes of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner as specified.

Auths, Mods and Denials: Prohibits a health plan or disability insurer that authorizes treatment by a provider pursuant to this bill from rescinding or modifying the authorization after the provider renders the health service in good faith and pursuant to this authorization for any reasons, including, but not limited to, the plan's or insurer's subsequent rescission, cancellation, or modification of the enrollee's or subscriber's contract or the policyholder's policy, or the plan's or insurer's subsequent determination that it did not make an accurate determination of the enrollee's or subscriber's, the insured's or policyholder's eligibility. Prohibits this from being construed to expand or alter benefits available under the plan or policy.

SB 855 ELEMENTS

Requires a health plan or disability insurer to base any medical necessity determination or the utilization review criteria that the plan or insurer, and any entity acting on the plan's or insurer's behalf, applies to determine the medical necessity of health services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorders.

States that "*generally accepted standards of mental health and substance use disorders*" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties; and valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

SB 855 ELEMENTS

Requires the health plan or disability insurer to apply the utilization review criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty. Prohibits a health plan or disability insurer from applying different, additional, conflicting, or more restrictive utilization review criteria.

Makes void and unenforceable on or after January 1, 2021 a provision in a health plan contract that reserves discretionary authority to the plan, or an agent of the plan, to determine eligibility for benefit or coverage, to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state.

SB 855 INDUSTRY CONCERNS

CAHP and ACLHIC have convened a joint trades workgroup to discuss the implementation issues. The workgroup is requesting clarity from the DMHC and CDI on the implementation date, scope of services required under the bill, and clinical guidelines that may be used to assess medical necessity.

AB 2520 - ACCESS TO MEDICAL RECORDS

AB 2520 expands the ability of a patient to obtain a copy, at no charge, of the relevant portion of the patient's medical records that are needed to support a claim or appeal regarding that patient's eligibility criteria for public programs.

PERSONAL PROTECTIVE EQUIPMENT BILLS

2020 Annual Conference

Industry Collaboration Effort

- **AB 2537:** Hospitals required to create a stockpile of PPE by April 1, 2021 based on 90 days of normal consumption.

- **SB 275:** - Creates an advisory committee to establish PPE stockpile standards. The recommendation will form the basis of regulatory development by CalOSHA.

INCREASED ACCESS TO PROVIDERS: Independent Practice

2020 Annual Conference

Industry Collaboration Effort

- **AB 890:** Nurse Practitioners
- **SB 1237:** - Certified Nurse Midwives

AB 890 - NP SCOPE OF PRACTICE WITHOUT STANDARDIZED PROCEDURES

Does not change existing scope of practice for NPs who utilize standardized procedures with a physician and wish to continue that arrangement

Authorizes a 3-year "transition to practice" with additional education, examination and certification to practice without standardized procedures in a physician-attended setting

Authorizes an additional certification with a further precondition 3-year practice requirement to practice outside of a physician setting without standardized procedures, but requires referral protocols to physicians

Creates a special Committee of the Bureau of Registered Nursing to make recommendations on educational and licensure requirements, and for discipline

Further regulations will need to be developed prior to January 1, 2023 implementation date. This bill is tied to SB 1237 – nurse midwives, as well

SB 1237 - NURSE-MIDWIVES SCOPE OF PRACTICE EXPANSION

This bill removes the requirement for a certified nurse midwife (CNM) to practice midwifery according to standardized procedures or protocols with a physician

Revises the provisions defining the practice of midwifery

Authorizes a CNM to attend cases out of a hospital setting

Authorizes a CNM to furnish or order drugs or devices in accordance with standardized protocols with a physician

Requires a CNM to provide specified disclosures to a patient; and establishes new reporting and data collection requirements

BEHAVIORAL HEALTH TELEMEDICINE

- **AB 3242:** Allows telehealth to be used for evaluating patients who are involuntarily committed.

HOSPITAL CLOSURE NOTICES

- **AB 2037:** Requires extended notice for reducing service or closing a facility.

- Hospitals that provide emergency medical services to provide public notice at least 180 days before a planned reduction or elimination of the level of emergency medical services.
- Health facility to provide at least 120 days' public notice prior to closing the health facility and at least 90 days prior to eliminating or relocating a

SB 852 PRESCRIPTION DRUGS

2020 Annual Conference

Industry Collaboration Effort

SB 852 requires the California Health and Human Services Agency (HHS) to enter into partnerships resulting in the production or distribution of **generic prescription drugs**, with the intent that these drugs be made widely available to public and private purchasers, providers and suppliers, and pharmacies.

Requires these generic drugs to be produced or distributed by a drug manufacturer that is registered with the FDA.

Requires HHS to only enter into partnerships to produce a generic drug at a price that results in savings, targets failures in the market for generic drugs, and improves patient access to affordable medications.

Requires each drug to be made available to providers, patients, and purchasers at a transparent price and without rebates, other than federally required rebates

2021 PREVIEW

- COVID-19
- Economy/State Budget
- Health Care Affordability
- Future of the ACA
- Testing / Vaccine
- Provider Solvency Issues
- Mental Health
- Revival of Failed Legislation
  - Utilization Management
  - Drug Copay Caps
  - Mandates