AMERICA'S PHYSICIAN GROUPS

CALIFORNIA 2018 LEGISLATIVE AND REGULATORY SUMMARY

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AMERICA'S PHYSICIAN GROUPS

AGENDA

New Health Laws for 2019

Regulatory Outlook

LAWS THAT AFFECT PROVIDERS

NEW HEALTH LAWS FOR 2019

THE CALIFORNIA LEGISLATURE

Bills are introduced in January and finalized by October

They typically become effective by January 1 of the next year, although some have alternate implementation dates

The Assembly and Senate each have Health Committees with full-time consultant staff and assigned Legislators

Assembly Health Chair: Jim Wood, Dentist from Sonoma County

Senate Health Chair: Richard Pan, Physician from Sacramento County

2018 LEGISLATIVE THEMES

- The Legislature had significant concerns over the following issues in this past year's session, but not all of these areas were ultimately addressed:
- Single payer supporters lobbied hard for passage of SB 562, but it stalled
- Cost control advocates (labor union trusts and employers) worked to dismantle consolidated provider systems and create provider rate regulation
- The Legislature sought to address the opioid addiction problem through several bills
- Advocates for behavioral health integration and reform sponsored several bills
- Trump administration efforts to incorporate alternatives to the Affordable Care Act through short term plans were resisted, and made illegal in California

MERGERS & ACQUISITIONS

- AB 595 (Wood)
- Gives the Department of Managed Health Care, a State agency with jurisdiction over all HMO business the authority to:
  - Conduct public hearings on health plan mergers with other entities
  - New standards for the consideration of mergers, such as whether they will produce lower health care premiums, or increase competition in the market
  - New authority to deny mergers that don't present increased value to the market
  - Becomes effective on January 1, 2019
  - Uncertainty over whether pending merger deals will be held until the new law becomes effective

DRUG COSTS

- AB 1860 (Limón)
- Copays and Coinsurance limits for prescribed, oral anticancer drugs will be limited to $250 per month
- Applies to all HMO and PPO plans in California, but not to self-insured employer plans (ERISA)
- Becomes effective for plan renewals after January 1, 2019 and sunsets on January 1, 2024

- AB 2863 (Nazarian)
- Pharmacists must inform a customer whether the retail price for a prescribed drug is lower than the applicable member cost-sharing amount
- Prohibits health plans from requiring copays or coinsurance amounts if the drug cost is lower than the applicable cost-sharing amount
- Becomes effective January 1, 2019

PRESCRIBER REQUIREMENTS

- AB 2789 (Wood)
- Electronic Prescribing
- All prescribers must be capable of electronic prescribing by January 1, 2022
- All prescriptions for controlled substances shall be transmitted electronically by January 1, 2022

- AB 2086 (Gallagher)
- All prescribers of controlled substances shall be allowed to review a Department of Justice list of patients for whom they are listed as being the prescriber under the CURES Database Access
- Becomes effective on January 1, 2019

PHARMACY BENEFIT MANAGERS

The Department of Managed Healthcare will register PBMs under a new law, AB 315 (Wood)

The law imposes a duty of good faith and fair dealing in the performance of contractual relationships

Disclosure of conflicts of interest to purchasers

Disclosure of drug acquisition, rebates and rates negotiated with pharmacies upon a purchaser's request

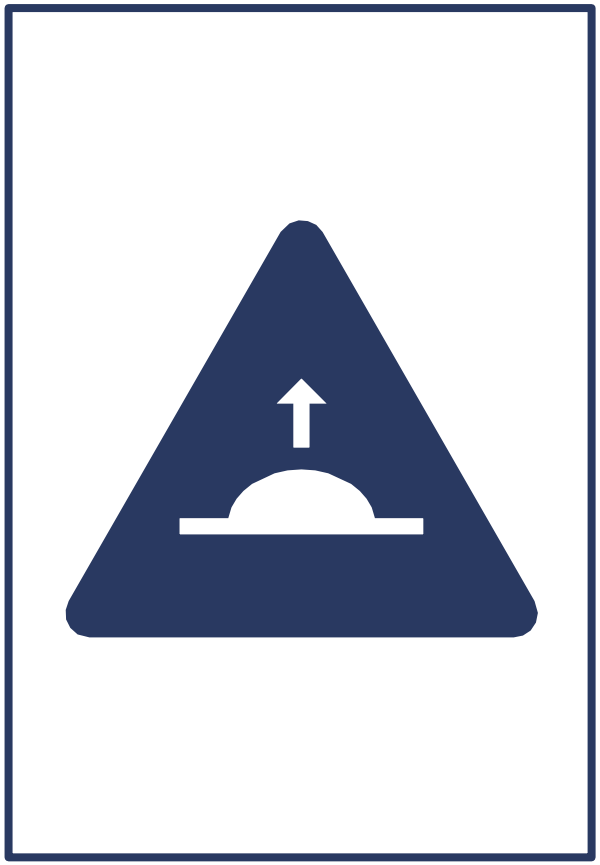
Contract provisions preventing the disclosure of cheaper alternative drugs or prices for the same drugs are void as against public policy

The bill becomes effective on January 1, 2019

PBM PILOT IN RIVERSIDE COUNTY

- AB 315 also provides for a pilot in Riverside and Sonoma Counties
- To assess the impact of health care service plan and pharmacy benefit manager prohibitions on the dispensing of certain amounts of prescription drugs by network retail pharmacies
- Bars a plan or a PBM from prohibiting a pharmacy provider from dispensing a particular amount of a prescribed medication if the plan or PBM allows that amount to be dispensed through a pharmacy owned or controlled by the plan or PBM

STATE OF EMERGENCY



- Health plans will be required to provide enrollees displaced during a declared state of emergency with access to medically necessary health care services
- Must file a plan within 48 hours describing how existing services have been impacted, how they will compensate, how they will communicate with enrollees, and how they will ensure continuity of care
- Relaxes time limits for authorizations, precertification or referrals
- Extends filing deadlines for claims
- Suspends prescription refill limitations, and includes out-of-network pharmacies
- Allows access to out-of-network providers
- Requires a toll-free telephone number for enrollee assistance with problems
- **Could become a delegated requirement for APG members from the Plan**

HEALTH PLAN OVERSIGHT

- AB 2674 (Augiar-Curry) requires the Department of Managed Healthcare to review provider-generated complaints about unfair payment patterns on an annual basis
- Authorizes DMHC to conduct a special audit or enforcement action
- Becomes effective on July 1, 2019

NETWORK ADEQUACY

Current Knox Keene Law requires 1 primary care physician for each 2,000 enrollees and 1 physician for every 1,200 enrollees. Prior legislation enacted in 2013 enabled a practice utilizing supervised, nonphysician medical practitioners to increase that ratio by an additional 1,000 lives. That legislation had a sunset provision.

SB 997(Monning) eliminates the sunset provision and makes the expansion of physician to enrollee ratio permanent. Nonphysician medical practitioners are defined as a physician assistant, certified nurse-midwife, or a nurse practitioner.

Thus, the bill enables small practices to greatly increase their value to managed care plans by adding significant additional capacity to the plan's network.

SINGLE PAYER LEGISLATION STALLED

- Single payer legislation (SB 562) passed the Senate but was held in the Assembly this past year
- A political alternative was considered and enacted under State Budget Legislation (AB 1810) to create a Council on Health Care Delivery Systems to review future models to achieve universal coverage for all Californians under a single, unified system. That same budget legislation also authorized the creation of an all-payer claims database at OSHPD within the next 3 years, to support any future system
- Additionally, AB 2472 (Wood) requires the Council to prepare a feasibility analysis on the creation of a public health insurance plan option (Public Option) to increase choice and competition for health care consumers. The analysis must be complete by October, 2021

PROVIDER RATE REGULATION STALLED

- AB 3087 (Kalra) would have created a new, independent state agency to oversee the development of provider fee-for-service rates. Providers would have had to seek approval from this Commission to increase their rates and if they couldn't make a viable showing, their application would have been denied
- The bill also included complex provisions on the oversight of capitated payment and alluded to indexing it to Medicare Advantage, but upon questioning, the proponents really could not explain how that would work
- APG opposed the bill but worked with the author, Ash Kalra, to better understand how the capitated-delegated model works. The author agreed to hold the bill in Committee as other alternatives to cost control are considered

EMERGING DEVELOPMENTS AFFECTING PROVIDERS

REGULATORY OUTLOOK

REGULATIONS

- Regulations are developed by state agencies and departments to clarify and implement legislation
- While the Legislature creates statutory law, like the Knox Keene Act, it is implemented and clarified by the Department of Managed Health Care through regulations under Title 28 of the California Code of Regulations
- APG focuses on these two areas of legislation and regulation, as well as others that affect physician practice and Medi-Cal
- Regulations are developed differently than legislation, and they can be significantly more impactful to physician practice in California managed care

- DMHC regulation still under development, but will likely implement the following:
- Greater transparency of complex relationships between plans and delegated physician groups
- RBOs are capitated physician groups that are delegated administrative functions by the plan, such as downstream claims payment of other providers, like ER services
- Will require higher amounts of capital to be infused into the RBO as a reserve and less reliance on sponsoring organizations, AR's, and IBNR
- Will require quarterly rather than annual compliance filings for smaller RBOs
- New filing forms that require greater detail on financial operations

RISK BEARING ORGANIZATION REGULATIONS

NON-CONTRACTED PROVIDER PAYMENT

AB 72 and the subsequent regulation established a new standard for payment of non-contracted providers of non-emergent, facilities-based services to covered enrollees. This law banned patient balance billing for these services

A default payment rate of no less than 125% of the applicable Medicare Fee Schedule (typically applies to radiology and pathology)

An average contracted rate methodology by the plan or delegated RBO based on the final DMHC regulation (typically applies to anesthesiology)

A dispute resolution program operated by the DMHC in Sacramento to resolve payment disputes over the amount of the "average contracted rate."

DMHC will brief APG members at the November 7th Contracts Committee meeting in Los Angeles

HEALTH PLAN LICENSURE

- A regulation to formally establish the "Restricted License" in the Knox Keene Act – which includes Primecare, one of the original "Limited Licensees"
- RKKs, as they are referred to, accept global capitation from a fully-licensed health plan (both hospital and professional cap) and are fully-regulated by the DMHC, unlike RBOs, which are just monitored by the Department
- There has been a growing number of applications for RKK licenses and the Department wanted to formalize the process under regulation
- But the Department redefined "global risk" as broader than just hospital and professional capitation, to other kinds of global payments that are not capitated, and the industry does not understand how this will work
- The regulation may affect non-capitated ACOs in Medicare, and commercial HMO and PPO ACOs – it is uncertain at this time

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