

CALIFORNIA POLICY COMMITTEE

MARCH 21, 2019

General Member Briefing
2:00 – 3:00 PM

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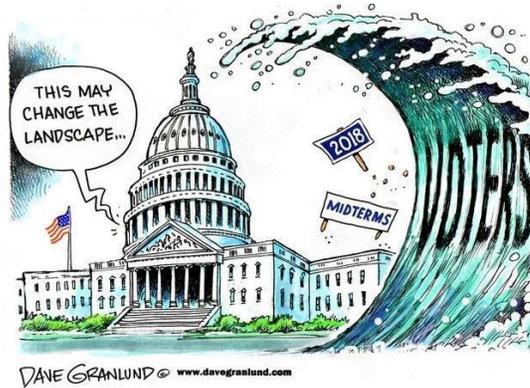
AGENDA

- 2:00 pm: Welcome & Introductions: Paul Durr, Chair CEO Sharp Community Medical Group
- Legislative Update: APG High Priority Bills in the 2019 Session
- Newly Adopted DMHC Global Risk Regulation & APG-Sponsored Global Risk Pilot Bill (AB 1249)
- New Business
- Adjournment

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CALIFORNIA POLITICAL LANDSCAPE. NOV. 18 MID-TERMS

- Democrats, who already held strong majorities *increased* their numbers.
- After the election, the Legislature includes:
 - In the 80 member Assembly:
 - 60 Dems; 20 Reps.
 - In the 40 member Senate:
 - 29 Dems to 11 Rep
- In addition, recently one Assembly Republican switched parties **NOW** making the California Assembly 61 Dems to 19 Reps.

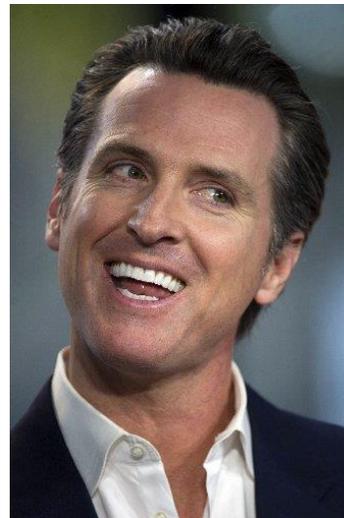


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DEMOCRATS ADDITIONAL GAINS

- Democrats hold all statewide elected offices, including the Governor's Office.
- Democrats pick up 6 congressional seats.
- Mid-terms are traditionally the Republicans stronger year.



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RX PRICING: EXEC. ORD. N-01-19 PART I

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- **Findings:** “establishing a single-purchaser for the highest-cost prescription drugs that will yield valuable insights into the design of a broader single-payer system, and move the State one step closer to a comprehensive solution for affordable and accessible health care for all.”
- **Orders:**
 - DHCS to take all necessary steps to transition all pharmacy services for Medi-Cal managed care to a fee-for-service benefit by 1/21.
 - DGS to develop a list of prescription drugs that can be prioritized for future bulk purchasing initiatives or reexamined for potential renegotiation with the manufacturer.
 - In developing the list, DGS must consider the **25 highest-cost prescription drugs**, which collectively account for approximately half of the State’s prescription drug expenditures.
 - Report of these prioritized drugs due to the Governor by 3-15-19.

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RX PRICING: EXEC. ORD. N-01-19 PART 2

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- DGS to develop and implement bulk purchasing arrangements for high-priority drugs based on the prioritized list by **4-12-19**.
- DGS to develop framework for enabling private purchasers to benefit from State bulk pharmaceutical purchasing;
 - The framework should incorporate the opportunity for private purchasers--including small businesses, health plans, and the self-insured--to opt in to a State purchasing program.

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RX PRICING: EXEC. ORD. N-01-19 PART 3

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- DHCS proposed a similar approach in 2014.
 - The proposal failed with opposition from managed care plans.
- Instead, CA adopted SB 870 from 2014 which authorized DHCS to collect supplemental rebates on specified “high cost drugs”
 - These “high cost drugs” included treatments for Hep C, HIV/AIDS, oncology, blood factors.

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RX PRICING: EXEC. ORD. N-01-19 PART 4

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- Senate Budget Hearing on the proposal:
 - PhRMA was neutral on the Executive Order.

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GOVERNOR'S LETTER TO PRESIDENT AND CONGRESS. PART 1.

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- 1/7/19, Governor Newsom sends letter to President Trump and Congressional leaders to request empowering “States like mine to design and implement truly transformative solutions for securing affordable health care for all.”
- Letter requests: “amend federal law to enable State to apply for and receive Transformative Cost and Universal Coverage Waivers, empowering California to truly innovate and to begin transformative reforms that provide the path to a single-payer health care system.”

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GOVERNOR'S LETTER TO PRESIDENT AND CONGRESS. PART 2.

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- **TRANSFORMATION COST AND COVERAGE WAIVERS:**
 - Assure competition by making public plan options available in areas with limited health carriers;
 - Use tools such as all-payer pricing to address rising health care costs;
 - Promote improvements to how care is delivered, supporting care coordination and payment systems that reward better quality;
 - “Unlike the current standards tied to ‘budget neutrality,’ this new waiver would be fiscally aligned with the federal government’s goal of reducing the uninsured, lowering costs, and improving quality.”
 - “The waivers would serve as the funding mechanism rewarding States that are relatively more successful in achieving these goals. For example, additional funding should be made available for States that are more effective at lowering the rate of the eligible uninsured, containing costs effectively, and promoting quality.”

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GOVERNOR'S LETTER TO PRESIDENT AND CONGRESS. PART 3.



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NEW 2019 PENDING LEGISLATION

BILLS INTRODUCED FOR THIS SESSION

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ACA COVERAGE EXPANSION

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- AB 4 (Arambula) & SB 29 (Durazo) full-scope Medi-Cal eligibility for all ages regardless of immigration status
- AB 414 (Bonta) & SB 175 (Pan) Individual mandate
- AB 537 (Arambula) Medi-Cal value-based financial incentives

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AB 1249 (MAIENSCHN): DIRECT CONTRACTING

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- APG is a co-sponsor along with Cal-VEBA (a voluntary employee benefits manager for teachers.)
- AB 1249:
 - Establishes a 5-year pilot to permit direct contracting for health services between a VEBA or Taft-Hartley Trust Fund, and provider groups that utilize risk-based, or global risk payment.
 - The 5-year pilot would include one pilot in northern California, and one in southern California.
 - Purpose of the pilot is to demonstrate the healthcare cost and quality benefits of provider risk-based payments versus fee for service.
 - At the end of the pilot, a report is required to be sent to the Legislature regarding the costs and clinical patient outcomes of the program.
 - Discussions with the Legislature and labor stakeholders have been VERY positive.

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SB 714 (UMBERG): DMHC GLOBAL RISK REGULATION

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- SB 714 (Umberg): currently in spot form. Vehicle to address concerns about the recently approved DMHC regulation on global risk.
- Coalition partners include the California Hospital Association.
- SB 714 will be amended to address concerns relating to DMHC's overly broad definition of "global risk" which would include shared-savings arrangements like those found in ACOs. Current language establishes a 25% risk threshold.

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SB 503 (PAN): MEDI-CAL MANAGED CARE; DELEGATED ENTITIES

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- SB 503:
 - Provides that a Medi-Cal managed care plan (MCP) "shall ensure compliance with existing law, and that this obligation is not waived if the contractor either subcontracts with or delegates any duties to a medical group" IPA or other entity.
- Sponsored by the Western Center on Law and Poverty.
- According to the author:
 - "recent events illustrate that patient care can suffer when layers of delegation and sub-delegation occur without appropriate oversight and transparency."
 - "A whistleblower complaint in 2017 shed light on a subcontractor falsifying documents to conceal improper denials of care."
 - SB 503 "makes clear that MCPs bear ultimate responsibility for those services, regardless of subcontracting, delegation, or sub-delegation."

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AB 1174 (WOOD): ANESTHESIA SERVICES

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- Follow-up legislation to AB 72 (Bonta) which related to non-contracted provider services and balance billing.
 - AB 72 established a default payment methodology for disputes involving non-contracted provider services.
 - Anesthesiologists claim that payers are using the default payment methodology in AB 72 as a threat during contract negotiations.

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AB 1174 (WOOD): ANESTHESIA SERVICES

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Health plans are required to notify DMHC before the end, or plan-initiated termination, of a contract including anesthesia services.

- Upon receiving this notice, DMHC is required to issue a finding that upon termination of the contract, the plan will have in place contracts with anesthesiologists so that:
 - The plan has a contract with at least one anesthesiologist who is contracted with the relevant facility; and
 - An enrollee requiring anesthesia services has access to a contracted anesthesiologist.

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AB 1174 (WOOD): ANESTHESIA SERVICES

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- Provides that a violation of AB 1174 constitutes grounds for disciplinary action against the plan.
- Delegated entities are required to notify the plan of the end, or termination by the entity, of a contract including anesthesia services.
 - Upon this notification, the plan is required to submit this information to the DMHC and be subject to the findings and provisions listed above.

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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 engage in an independently established trade, occupation, or business of the same nature as the work performed.**
 - Prong 2 is particularly problematic.
 - AB 5 is in spot form but is seeking to codify the *Dynamex* decision:
 - Numerous stakeholders (including APG) are working with the author on provisions needed to make the *Dynamex* decision workable.

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MEDIUM PRIORITY BILLS

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Suggested positions:

- SB 343 (Pan) Healthcare Data Disclosure (Concerns)
- SB 347 (Monning) Soda Warning Labels (Support)
- AB 890 (Wood) N.P.Autonomy (Support if Amended)
- SB 697 (Caballero) P.A. Optimal Team Practice (Support)

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NEWLY ADOPTED DMHC GLOBAL RISK REGULATION & APG-SPONSORED GLOBAL RISK PILOT BILL (AB 1249)

BILL BARCELLONA

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DMHC RISK REGULATION & AB 1249

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- Implications for APG members in the Global Risk Licensure Regulation
- APG response Global Risk Pilot Bill (AB 1249):
 - Criteria and standardization for industry

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TITLE 28, SECTION 1300.49

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- “Global risk” means the acceptance of a prepaid or periodic charge from or on behalf of enrollees in return for the assumption of both professional and institutional risk.
- “Prepaid or periodic charge” for the purposes of this section means any amount of compensation, either at the start or end of a predetermined period, for assuming the risk, or arranging for others to assume the risk, of delivering or arranging for the delivery of the contracted-for health care services for subscribers or enrollees that may be fixed either in amount or percentage of savings or losses in which the entity shares.

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TITLE 28, SECTION 1300.49

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- “Institutional risk” means the assumption of the cost for the provision of hospital inpatient, hospital outpatient, or hospital ancillary services to subscribers or enrollees undertaken by a person, other than services performed pursuant to the person’s own license under section 1253 of the Health and Safety Code, in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

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TITLE 28, SECTION 1300.49

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- “Restricted health care service plan” means a person with a health care service plan license issued by the Department for the provision of, or the arranging, payment, or reimbursement for the provision of, health care services to subscribers or enrollees of another full service or specialized health care service plan under a contract or other arrangement whereby the person assumes both professional and institutional risk but does not directly market, solicit, or sell health care service plan contracts.

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FURTHER INFORMATION

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- March 28 Webinar: 12:00 – 1:00 pm (PDT)
- Crowell Moring and Mazars consulting will conduct a briefing to cover:
 - How the new licensure regulation changes existing law;
 - How the regulation may impact providers, health plans, and employers; and
 - What to expect when requesting an exemption or seeking a license.

Registration [link](#)

We expect other firms will soon provide briefings

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ADJOURNMENT

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Next meetings:

- Thursday, May 23rd
- Thursday, August 22nd
- Thursday, October 31st

Please mark your calendars

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