AUGUST 8, 2022

Proposition 29: Requires On-Site Licensed Medical Professional at Kidney Dialysis Clinics and Establishes Other State Requirements. Initiative Statute.

PRESENTED TO:

Senate Committee on Health
Hon. Richard Pan, Chair

Assembly Committee on Health
Hon. Jim Wood, Chair

LEGISLATIVE ANALYST'S OFFICE

LAO Role in Initiative Process

Fiscal Analysis Prior to Signature Collection

- State law requires our office to work with the Department of Finance to prepare a joint impartial fiscal analysis of each initiative before it can be circulated for signatures.
- State law requires that this analysis provide an estimate of the measure's fiscal impact on the state and local governments.
- A summary of the estimated fiscal impact is included on petitions that are circulated for signatures.

Analyses for Qualified Measures

- State law requires our office to provide impartial analyses of all statewide ballot propositions for the statewide voter information guide. This analysis includes a description of the proposition and its fiscal effects.

Background

Dialysis Treatment

- When a person's kidneys no longer function properly, the person either needs a kidney transplant or process called dialysis. Dialysis mimics what healthy kidneys do, filtering out waste and extra fluid from the blood supply.
- Patients typically require three dialysis treatments per week and each treatment typically lasts about four hours.
- Patients most often receive dialysis at clinics. California has about 650 licensed chronic dialysis clinics, which serve roughly 80,000 patients per month.
- A patient's own physician develops and oversees the course of dialysis treatment and must visit the patient at the clinic at least once per month during treatment.
- Various entities own and operate dialysis clinics. Two companies own or operate nearly 75 percent of clinics. Some owners and operators with multiple clinics can use a high-earning clinic to help support a clinic operating at a loss, however, this might not be sustainable in the long term.

Background

(Continued)

Paying for Dialysis

A few main sources pay for dialysis:

- ***Medicare.*** Federal law generally makes people with kidney failure eligible for Medicare coverage regardless of age or disability status. Medicare pays for dialysis treatment for the majority of people on dialysis in California.
- ***Medi-Cal.*** For people enrolled only in Medi-Cal, Medi-Cal alone pays for dialysis. For people who qualify for both Medicare and Medi-Cal, Medicare covers most of the payment for dialysis as the main payer and Medi-Cal covers the rest.
- ***Group and Individual Health Insurance.*** When a person with group or individual insurance develops kidney failure, that person can usually transition to Medicare coverage. Federal law requires a group insurer to be the main dialysis payer for the first 30 months of treatment. Group and individual health insurers typically pay higher rates for dialysis than government programs.

State government, including its two public university systems, and many local governments provide group health insurance for their current workers, eligible retired workers, and their families.

How Chronic Dialysis Clinics Are Regulated

- The California Department of Public Health (CDPH) licenses clinics to operate in California. It also certifies dialysis clinics on behalf of the federal government, which enables clinics to receive Medicare and Medi-Cal payments.
- Federal regulations require each clinic to have a medical director who is a board-certified physician, but do not require medical directors to spend a set amount of time at each clinic. The regulations state that this position generally reflects about one-quarter of a full-time position.
- Dialysis clinics must report infection-related information to the federal government.

Proposal

- ***Requires On-Site Medical Professional.*** Requires each dialysis clinic to have a physician, nurse practitioner, or physician assistant—with at least six months of experience providing care to kidney patients—on-site during all patient treatment hours. If the clinic is in an area with a shortage of these professionals, it can request a one-year exception from CDPH to fulfill the requirement via telehealth.
- ***Requires Regular Reporting by Clinics.*** Requires clinics to regularly report the following information and if they fail to do so, allows CDPH to assess a penalty of up to $100,000:
  - Reporting to CDPH of infection-related information, which must be posted on the CDPH website.
  - Reporting to patients about physicians who own at least 5 percent of the clinic.
  - Reporting to CDPH about persons who own at least 5 percent of the clinic. This information must be posted online by CDPH and the clinic.
- ***Requires CDPH to Consent to a Clinic Closure.*** Clinics must notify and obtain consent from CDPH before closing or substantially reducing services.
- ***Prohibits Clinics From Refusing Care to a Patient Based on Payer.*** Clinics must provide the same quality of care and cannot refuse care to patients based on who pays for their treatment.

Fiscal Effects

Increased Costs for Dialysis Clinics Could Increase Government-Funded Health Care Costs

Increased Costs for Clinics. Having a physician, nurse practitioner, or physician assistant on-site during all patient treatment hours would increase costs for each clinic by several hundred thousand dollars annually on average.

Clinics Generally Would Respond to Higher Costs in Various Ways. We assume clinics generally would respond to the proposition as follows:

- ***Negotiate Increased Rates With Some Payers.*** Clinic owners and operators may be able to negotiate higher rates with private commercial insurance companies and to a lesser extent with Medi-Cal managed care plans, particularly if many clinics were to close otherwise.
- ***Continue Current Operations, With Lower Profits.*** Some owners and operators may continue to operate with reduced income, but without closing any clinics.
- ***Close Some Clinics.*** Some owners and operators may decide to seek consent from CDPH to close some of their clinics that are operating at a loss.

Fiscal Effects

(Continued)

Increased Health Care Costs for State and Local Governments, Likely in the Tens of Millions of Dollars Annually. These clinic responses could increase state Medi-Cal costs and state and local employee and retiree health insurance costs due to:

- Owners and operators negotiating higher payment rates.
- Some patients requiring treatment in costlier settings like hospitals if some clinics closed in response to the proposition's requirements.

We estimate Proposition 29 would lead to increased costs for state and local governments likely in the tens of millions of dollars annually.

Increased CDPH Administrative Costs, Covered by Fees

The cost of CDPH's new regulatory responsibilities imposed by the proposition likely would not exceed the low millions of dollars annually. The proposition requires fees paid by clinics to cover these costs.