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REGULATES AMOUNTS OUTPATIENT KIDNEY DIALYSIS CLINICS CHARGE FOR DIALYSIS TREATMENT. INITIATIVE STATUTE.

OFFICIAL TITLE AND SUMMARY

PREPARED BY THE ATTORNEY GENERAL

The text of this measure can be found on the Secretary of State's website at <http://voterguide.sos.ca.gov>.

- Limits the charges to 115 percent of the costs for direct patient care and quality improvement costs, including training, patient education, and technology support.
- Requires rebates and penalties if charges exceed the limit.
- Requires annual reporting to the state regarding clinic costs, patient charges, and revenue.
- Prohibits clinics from refusing to treat patients based on the source of payment for care.

SUMMARY OF LEGISLATIVE ANALYST'S ESTIMATE OF NET STATE AND LOCAL GOVERNMENT FISCAL IMPACT:

- Overall annual effect on state and local governments ranging from net positive impact in the low tens of millions of dollars to net negative impact in the tens of millions of dollars.

ANALYSIS BY THE LEGISLATIVE ANALYST

BACKGROUND

DIALYSIS TREATMENT

Kidney Failure. Healthy kidneys filter a person's blood to remove waste and extra fluid. Kidney disease refers to when a person's kidneys do not function properly. Over time, a person may develop kidney failure, also known as "end-stage renal disease." This means that the kidneys no longer function well enough for the person to survive without a kidney transplant or ongoing treatment referred to as dialysis.

Dialysis Mimics Normal Kidney Functions. Dialysis artificially mimics what healthy kidneys do. Most people on dialysis undergo hemodialysis, a form of dialysis in which blood is removed from the body, filtered through a machine to remove waste and extra fluid, and then returned to the body. A hemodialysis treatment lasts about four hours and typically occurs three times per week.

Most Dialysis Patients Receive Treatment in Clinics. Individuals with kidney failure may

receive dialysis treatment at hospitals or in their own homes, but most receive treatment at chronic dialysis clinics (CDCs). As of May 2018, 588 licensed CDCs in California provided treatment to roughly 80,000 patients each month. Each CDC operates an average of 22 dialysis stations, with each station providing treatment to one patient at a time. The California Department of Public Health (CDPH) is responsible for licensing and inspecting CDCs. Various entities own and operate CDCs. As shown in Figure 1, two private for-profit entities operate and have at least partial ownership of the majority of CDCs in California.

PAYING FOR DIALYSIS TREATMENT

Payment for Dialysis Treatment Comes From a Few Main Sources. We estimate that CDCs have total revenues of roughly \$3 billion annually from their operations in California. These revenues consist of payments for dialysis treatment from a few main sources, or "payers":

ANALYSIS BY THE LEGISLATIVE ANALYST

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Figure 1

Licensed Chronic Dialysis Clinics in California

May 2018

| Operating Entity | Number of Clinics | Percent of Clinics |
|-------------------------------------|-------------------|--------------------|
| DaVita, Inc. (for-profit) | 292 | 50% |
| Fresenius Medical Care (for-profit) | 129 | 22 |
| Satellite Healthcare (nonprofit) | 46 | 8 |
| U.S. Renal Care (for-profit) | 38 | 6 |
| Other | 83 | 14 |
| Totals | 588 | 100% |

- Medicare.** This federally funded program provides health coverage to most people age 65 and older and certain younger people who have disabilities. 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.** The federal-state Medicaid program, known as Medi-Cal in California, provides health coverage to low-income people. The state and the federal government share the costs of Medi-Cal. Some people qualify for both Medicare and Medi-Cal. For these people, Medicare covers most of the payment for dialysis treatment as the primary payer and Medi-Cal covers the rest. For people enrolled only in Medi-Cal, the Medi-Cal program is solely responsible to pay for dialysis treatment.
- Group and Individual Health Insurance.** Many people in the state have group health insurance coverage through an employer or another organization (such as a union). The California state government, the state’s two public university systems, and many local governments in California provide group health insurance coverage for their current workers, eligible retired

workers, and their families. Some people without group health insurance purchase health insurance individually. Group and individual health insurance coverage is often provided by a private insurer that receives a premium payment in exchange for covering the costs of an agreed-upon set of health care services.

When an insured person develops kidney failure, that person can usually transition to Medicare coverage. Federal law requires that a group insurer remain the primary payer for dialysis treatment for a “coordination period” that lasts 30 months.

Group and Individual Health Insurers Typically Pay Higher Rates for Dialysis Than Government Programs.

The rates that Medicare and Medi-Cal pay for dialysis treatment are relatively close to the average cost for CDCs to provide a dialysis treatment and are largely determined by regulation. In contrast, group and individual health insurers establish their rates by negotiating with CDCs. The rates paid by these insurers depend on the relative bargaining power of insurers and the CDCs. On average, group and individual health insurers pay multiple times what government programs pay for dialysis treatment.

PROPOSAL

Requires Clinics to Pay Rebates When Total Revenues Exceed a Specified Cap. Beginning in 2019, the measure requires CDCs each year to calculate the amount by which their revenues exceed a specified cap. The measure then requires CDCs to pay rebates (that is, give money back) to payers, excluding Medicare and other government payers, in the amount that revenues exceed the cap. The more a

ANALYSIS BY THE LEGISLATIVE ANALYST

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payer paid for treatment, the larger the rebate the payer would receive.

Revenue Cap Based on Specified CDC Costs.

The revenue cap established by the measure is equal to 115 percent of specified “direct patient care services costs” and “health care quality improvement costs.” These include the cost of such things as staff wages and benefits, staff training and development, drugs and medical supplies, facilities, and electronic health information systems. Hereafter, we refer to these costs as “allowable,” meaning they can be counted toward determining the revenue cap. Other costs, such as administrative overhead, would not be counted toward determining the revenue cap.

Interest and Penalties on Rebated Amounts. In addition to paying any rebates, CDCs would be required to pay interest on the rebate amounts, calculated from the date of payment for treatment. CDCs would also be required to pay a penalty to CDPH of 5 percent of the amount of any required rebates, up to a maximum penalty of \$100,000.

Rebates Calculated at Owner/Operator Level.

The measure specifies that rebates would be calculated at the level of a CDC’s “governing entity,” which refers to the entity that owns or operates the CDC (hereafter “owner/operator”). Some owner/operators have many CDCs in California, while others may own or operate a single CDC. For owner/operators with many CDCs, the measure requires them to add up their revenues and allowable costs across all of their CDCs in California. If the total revenues exceed 115 percent of total allowable costs across all of an owner/operator’s clinics, they would be required to pay rebates equal to the difference.

Legal Process to Raise Revenue Cap in Certain Situations. Both the California Constitution and the United States Constitution prohibit the government from taking private property (which includes the value of a business) without fair legal proceedings or fair compensation. A

CDC owner/operator might try to prove in court that, in their particular situation, the required rebates would amount to taking the value of the business and therefore violate the state or federal constitution. If a CDC owner/operator is able to prove this, the measure outlines a process where the court would reduce the required rebates by just enough to no longer violate the constitution. The measure places on the CDC owner/operator the burden of identifying the largest amount of rebates that would be legal. The measure specifies that any adjustment in the rebate amount would apply for only one year.

Other Requirements. The measure requires that CDC owner/operators submit annual reports to CDPH. These reports would list the number of dialysis treatments provided, the amount of allowable costs, the amount of the owner/operator’s revenue cap, the amount by which revenues exceed the cap, and the amount of rebates paid. The measure also prohibits CDCs from refusing to provide treatment to a person based on who is paying for the treatment.

CDPH Required to Issue Regulations. The measure requires CDPH to develop and issue regulations to implement the measure’s provisions within 180 days of the measure’s effective date. In particular, the measure allows CDPH to identify through regulation additional CDC costs that would count as allowable costs, which could serve to reduce the amount of any rebates otherwise owed by CDCs.

FISCAL EFFECTS

MEASURE WOULD REDUCE CDC PROFITABILITY

Currently, it appears that CDCs operating in California have revenues in excess of the revenue cap specified in the measure. Paying rebates in the amount of the excess would significantly reduce the revenues of CDC owner/operators. In the case of CDCs operated by for-profit entities (the majority of CDCs),

ANALYSIS BY THE LEGISLATIVE ANALYST

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this means the CDCs would be less profitable or could even be unprofitable. This could lead to changes in how dialysis treatment is provided in the state. These changes could have various effects on state and local government finances. As described below, the impact of the measure on CDCs and on state and local government finances is uncertain. This is because the impact would depend on future actions of (1) state regulators and courts in interpreting the measure and (2) CDCs in response to the measure. These future actions are difficult to predict.

MAJOR SOURCES OF UNCERTAINTY

Uncertain Which Costs Are Allowable. The impact of the measure would depend on how allowable costs are defined. Including more costs as allowable would make revenue caps higher and allow CDCs to keep more of their revenues (by requiring smaller rebates). Including fewer costs as allowable would make revenue caps lower and allow clinics to keep less of their revenues (by requiring larger rebates). It is uncertain how CDPH (as the state regulator involved in implementing and enforcing the measure) and courts would interpret the measure’s provisions defining allowable costs. For example, the measure specifies that the costs of staff wages and benefits are only allowable for “non-managerial” staff that provide direct care to dialysis patients. Federal law requires CDCs to maintain certain staff positions as a condition of receiving Medicare reimbursement. Some of these required positions—including the medical director and nurse manager—perform managerial functions but are also involved in direct patient care. The costs of these positions might not be considered allowable because the positions have managerial functions. On the other hand, the costs of these positions might be considered allowable because the positions relate to direct patient care.

Uncertain How CDCs Would Respond to the Measure. CDC owner/operators would likely respond to the measure by adjusting their operations in ways that limit, to the extent possible, the effect of the rebate requirement. They could do any of the following:

- **Increase Allowable Costs.** CDC owner/operators might increase allowable costs, such as wages and benefits for non-managerial staff providing direct patient care. Increasing allowable costs would raise the revenue cap, reduce the amount of rebates owed, and potentially leave CDC owner/operators better off than if they were to leave allowable costs at current levels. This is because the amount of revenues that CDC owner/operators could retain would grow by more than the additional costs (the revenue cap would increase by 115 percent of additional allowable costs).
- **Reduce Other Costs.** CDC owner/operators might also reduce, where possible, other costs that do not count toward determining the revenue cap (such as administrative overhead). This would not change the amount of rebates owed, but it would improve the CDCs’ profitability.
- **Seek Adjustments to Revenue Cap.** If CDC owner/operators believe they cannot achieve a reasonable return on their operations even after making adjustments as described above, they might try to challenge the rebate provision in court to get a higher revenue cap as outlined in the measure. If such a challenge were successful, some CDC owner/operators might have a higher revenue cap and owe less in rebates in some years.
- **Scale Back Operations.** In some cases, owner/operators might decide to open fewer new CDCs or close some CDCs if the amount of required rebates is large and reduced revenues do not provide sufficient

ANALYSIS BY THE LEGISLATIVE ANALYST

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return on investment to expand or remain in the market. If this takes place, other providers would eventually need to step in to meet the demand for dialysis. These other providers might operate less efficiently (have higher costs). Some other providers could potentially be exempt from the provisions of the measure if they do not operate under a CDC license (for example, hospitals). Such broader changes in the dialysis industry are difficult to predict.

IMPACT OF REBATE PROVISIONS ON STATE AND LOCAL FINANCES

We estimate that, without actions taken by CDCs in response to the measure, potential rebates owed could reach several hundred million dollars. Depending on the factors discussed above, the measure's rebate provisions could have several types of effects on state and local finances.

Measure Could Generate State and Local Government Employee Health Care Savings . . .

To the extent that CDCs pay rebates, state and local government costs for employee health care could be reduced. As noted previously, the measure excludes government payers from receiving rebates. However, state and local governments often contract with private health insurers to provide coverage for their employees. As private entities, these insurers might be eligible for rebates under the measure. Even if they are not eligible for rebates, they would likely still be in a position to negotiate lower rates with CDC owner/operators. These insurers might pass some or all of these savings on to government employers in the form of reduced health insurance premiums.

. . . **Or Costs.** On the other hand, as described above, CDCs might respond to the measure by increasing allowable costs. If CDCs increase

allowable costs enough, rates that health insurers pay for dialysis treatment might increase above what they would have been in the absence of the measure. If this occurs, insurers might pass some or all of these higher costs on to government employers in the form of increased health insurance premiums.

State Medi-Cal Cost Pressures. The Medi-Cal program also contracts with private insurers to provide dialysis coverage for some of its enrollees. Similar to health insurers that provide coverage for government employees, private insurers that contract with Medi-Cal might also receive rebates (if they are determined to be eligible) or might be able to negotiate lower rates with CDC owner/operators. Some or all of these savings might be passed on to the state. However, because rates paid to CDCs by these insurers are relatively low, such savings would likely be limited. On the other hand, if CDCs respond to the measure by increasing allowable costs, the average cost of a dialysis treatment would increase. This would put upward pressure on Medi-Cal rates and could result in increased state costs.

Changes to State Tax Revenues. To the extent the measure's rebate provisions operate to reduce the net income of CDC owner/operators, the measure would likely reduce the amount of income taxes that for-profit owner/operators are required to pay to the state. This reduced revenue could be offset, to an unknown extent, by various other changes to state revenues. For example, additional income tax revenue could be generated if CDCs respond to the measure by increasing spending on allowable staff wages.

In Light of Significant Uncertainty, Overall Effect on State and Local Finances Is Unclear. Different interpretations of the measure's provisions and different CDC responses to the measure would lead to different impacts for state and local governments. In light of significant uncertainty

ANALYSIS BY THE LEGISLATIVE ANALYST

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about how the measure may be interpreted and how CDCs may respond, a range of possible net impacts on state and local government finances is possible.

Overall Effect Could Range From Net Positive Impact in the Low Tens of Millions of Dollars . . . If the measure is ultimately interpreted to have a broader, more inclusive definition of allowable costs, such as by including costs for nurse managers and medical directors, the amount of rebates CDC owner/operators are required to pay would be smaller. Under this interpretation, it is more likely that CDC owner/operators would respond with relatively modest changes to their cost structures. In this scenario, state and local government costs for employee health benefits could be reduced. These savings would likely be partially offset by a net reduction in state tax revenues. Overall, we estimate the measure could have a net positive impact on state and local government finances reaching the low tens of millions of dollars annually in this scenario.

. . . To Net Negative Impact in the Tens of Millions of Dollars. If the measure is ultimately interpreted to have a narrower, more restrictive definition of allowable costs, the amount of rebates CDC owner/operators are required to pay would be greater. Under this interpretation, it is more likely that CDC owner/operators would respond with more significant changes to their cost structures, particularly by increasing allowable costs. CDC owner/operators would also be more likely to seek adjustments to the revenue cap or scale back operations in the state. In this scenario, state and local government costs for employee health benefits and state Medi-Cal costs could increase. State tax revenues could also be reduced. Overall, we estimate the measure could have a net negative impact reaching

the tens of millions of dollars annually in this scenario.

Other Potential Fiscal Impacts. The scenarios described above represent our best estimate of the range of the measure’s likely fiscal impacts. However, other fiscal impacts are possible. As an example, if CDCs respond to the measure by scaling back operations in the state, some dialysis patients’ access to dialysis treatment could be disrupted in the short run. This could lead to health complications that result in admission to a hospital. To the extent that dialysis patients are hospitalized more frequently because of the measure, state costs—particularly in Medi-Cal—could increase significantly in the short run.

ADMINISTRATIVE IMPACT

This measure imposes new responsibilities on CDPH. We estimate that the annual cost to fulfill these new responsibilities likely would not exceed the low millions of dollars annually. The measure requires CDPH to adjust the annual licensing fee paid by CDCs (currently set at about \$3,400 per facility) to cover these costs. Some of these administrative costs may also be offset by penalties paid by CDCs related to rebates or failure to comply with the measure’s reporting requirements. The amount of any offset is unknown.

Visit <http://www.sos.ca.gov/campaign-lobbying/cal-access-resources/measure-contributions/2018-ballot-measure-contribution-totals/> for a list of committees primarily formed to support or oppose this measure. Visit <http://www.fppc.ca.gov/transparency/top-contributors/nov-18-gen.html> to access the committee’s top 10 contributors.

If you desire a copy of the full text of the state measure, please call the Secretary of State at (800) 345-VOTE (8683) or you can email vigfeedback@sos.ca.gov and a copy will be mailed at no cost to you.

accordance with Section 10 of Article II of the California Constitution.

This proposed law adds a section to the Government Code and repeals sections of the Daylight Saving Time Act; therefore, provisions proposed to be deleted are printed in ~~strikeout type~~ and new provisions to be added are printed in *italic type* to indicate that they are new.

PROPOSED LAW

SECTION 1. If federal law authorizes the state to provide for the year-round application of daylight saving time and the Legislature considers the adoption of this application, it is the intent of this act to encourage the Legislature to consider the potential impacts of year-round daylight saving time on communities along the border between California and other states and between California and Mexico.

SEC. 2. Section 6808 is added to the Government Code, to read:

6808. (a) The standard time within the state is that of the fifth zone designated by federal law as Pacific standard time (15 U.S.C. Secs. 261 and 263).

(b) The standard time within the state shall advance by one hour during the daylight saving time period commencing at 2 a.m. on the second Sunday of March of each year and ending at 2 a.m. on the first Sunday of November of each year.

(c) Notwithstanding subdivision (b), the Legislature may amend this section by a two-thirds vote to change the dates and times of the daylight saving time period, consistent with federal law, and, if federal law authorizes the state to provide for the year-round application of daylight saving time, the Legislature may amend this section by a two-thirds vote to provide for that application.

SEC. 3. Section 1 of the Daylight Saving Time Act is repealed.

~~Section 1. This act shall be known and may be cited as the Daylight Saving Time Act.~~

SEC. 4. Section 2 of the Daylight Saving Time Act is repealed.

~~Section 2. The standard time within the State, except as hereinafter provided, is that of the One Hundred and Twentieth (120th) degree of longitude west from Greenwich and which is~~

~~now known, described and designated by Act of Congress as "United States Standard Pacific Time."~~

SEC. 5. Section 3 of the Daylight Saving Time Act is repealed.

~~Sec. 3. From 1 o'clock antemeridian on the last Sunday of April, until 2 o'clock antemeridian on the last Sunday of October, the standard time in this State so established shall be one hour in advance of the standard time now known as United States Standard Pacific time.~~

SEC. 6. Section 4 of the Daylight Saving Time Act is repealed.

~~Section 4. In all laws, statutes, orders, decrees, rules and regulations relating to the time of performance of any act by any officer or department of this State, or of any county, city and county, city, town or district thereof or relating to the time in which any rights shall accrue or determine, or within which any act shall or shall not be performed by any person subject to the jurisdiction of the State, and in all the public schools and in all other institutions of this State, or of any county, city and county, city, town or district thereof, and in all contracts or choses in actions made or to be performed in this State, the time shall be as set forth in this act and it shall be so understood and intended.~~

SEC. 7. Section 5 of the Daylight Saving Time Act is repealed.

~~SECTION 5. All acts in conflict herewith are hereby repealed.~~

PROPOSITION 8

This initiative measure is submitted to the people in accordance with the provisions of Section 8 of Article II of the California Constitution.

This initiative measure adds sections to the Health and Safety Code; therefore, new provisions proposed to be added are printed in *italic type* to indicate that they are new.

PROPOSED LAW

SECTION 1. Name.

This act shall be known as the "Fair Pricing for Dialysis Act."

SEC. 2. Findings and Purposes.

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This act, adopted by the people of the State of California, makes the following findings and has the following purposes:

(a) The people make the following findings:

(1) Kidney dialysis is a process where blood is cleaned of waste and excess water, usually through a machine outside the patient's body, and then returned to the patient. If someone who needs dialysis cannot obtain or afford high quality care, toxins build up in the body, leading to death.

(2) In California, at least 66,000 Californians undergo dialysis treatment.

(3) Just two multinational, for-profit corporations operate or manage nearly three-quarters of dialysis clinics in California and treat almost 70 percent of dialysis patients in California. These two multinational corporations annually earn billions of dollars from their dialysis operations, including almost \$400 million each year in California alone.

(4) Because federal law mandates that private health insurance companies offer and pay for dialysis, private insurance companies have little ability to bargain with the two multinational dialysis corporations on behalf of their customers.

(5) Thus, for-profit dialysis corporations charge patients with private health insurance four times as much as they charge Medicare for the very same dialysis treatment, resulting in vast profits.

(6) In a market dominated by just two multinational corporations, California must ensure that dialysis is fairly priced and affordable.

(7) Other states have taken steps to protect these very vulnerable patients from these two multinational corporations.

(8) Efforts to enact protections for kidney dialysis patients in California have been stymied in Sacramento by the dialysis corporations, which spent over \$600,000 in just the first six months of 2017 to influence the California Legislature.

(b) Purposes:

(1) It is the purpose of this act to ensure that outpatient kidney dialysis clinics provide quality and affordable patient care to people suffering from end stage renal disease.

(2) This act is intended to be budget neutral for the state to implement and administer.

SEC. 3. Section 1226.7 is added to the Health and Safety Code, to read:

1226.7. (a) Reasonable limits on charges for patient care by chronic dialysis clinics; rebates of amounts charged in excess of fair treatment payment amount.

(1) For purposes of this section, the "fair treatment payment amount" shall be an amount equal to 115 percent of the sum of all direct patient care services costs and all health care quality improvement costs incurred by a governing entity and its chronic dialysis clinics.

(2) For each fiscal year starting on or after January 1, 2019, a governing entity or its chronic dialysis clinics shall annually issue rebates to payers as follows:

(A) The governing entity shall calculate the "unfair excess charged amount," which shall be the amount, if any, by which treatment revenue from treatments provided by all of the governing entity's chronic dialysis clinics exceeds the fair treatment payment amount.

(B) The governing entity or its chronic dialysis clinics shall, on a pro rata basis based on the amounts paid and reasonably estimated to be paid, as those amounts are included in treatment revenue, issue rebates to payers (other than Medicare or other federal, state, county, city, or local government payers) in amounts that total the unfair excess charged amount.

(C) The governing entity or chronic dialysis clinic shall issue any rebates required by this section no less than 90 days and no more than 210 days after the end of its fiscal year to which the rebate relates.

(D) If, in any fiscal year, the rebate the governing entity or chronic dialysis clinic must issue to a single payer is less than twenty dollars (\$20), the governing entity or chronic dialysis clinic shall not issue that rebate and shall provide to other payers in accordance with subparagraph (B) the total amount of rebates not issued pursuant to this subparagraph.

(E) For each fiscal year starting on or after January 1, 2020, any rebate issued to a payer shall be issued together with interest thereon at the rate of interest specified in subdivision (b)

of Section 3289 of the Civil Code, which shall accrue from the date of payment by the payer.

(3) For each fiscal year starting on or after January 1, 2019, a governing entity shall maintain and provide to the department, on a form and schedule prescribed by the department, a report of all rebates issued under paragraph (2), including a description of each instance during the period covered by the submission when the rebate required under paragraph (2) was not timely issued in full, and the reasons and circumstances therefor. The chief executive officer or principal officer of the governing entity shall certify under penalty of perjury that he or she is satisfied, after review, that all information submitted to the department under this paragraph is accurate and complete.

(4) In the event a governing entity or its chronic dialysis clinic is required to issue a rebate under this section, no later than 210 days after the end of its fiscal year the governing entity shall pay a penalty to the department in an amount equal to 5 percent of the unfair excess charged amount, provided that the penalty shall not exceed one hundred thousand dollars (\$100,000). Penalties collected pursuant to this paragraph shall be used by the department to implement and enforce laws governing chronic dialysis clinics.

(5) If a chronic dialysis clinic or governing entity disputes a determination by the department to assess a penalty pursuant to this subdivision or subdivision (b), or the amount of an administrative penalty, the chronic dialysis clinic or governing entity may, within 10 working days, request a hearing pursuant to Section 131071. A chronic dialysis clinic or governing entity shall pay all administrative penalties when all appeals have been exhausted and the department's position has been upheld.

(6) If a governing entity or chronic dialysis clinic proves in any court action that application of this section to the chronic dialysis clinic or governing entity will, in any particular fiscal year, violate due process or effect a taking of private property requiring just compensation under the Constitution of this state or the Constitution of the United States, the provision at issue shall apply to the governing entity or chronic dialysis clinic, except that as to the fiscal year in question the number "115" whenever it appears in the provision at issue

shall be replaced by the lowest possible whole number such that application of the provision to the governing entity or chronic dialysis clinic will not violate due process or effect a taking of private property requiring just compensation. In any civil action, the burden shall be on the governing entity or chronic dialysis clinic to propose a replacement number and to prove that replacing "115" with any whole number lower than the proposed replacement number would, for the fiscal year in question, violate due process or effect a taking of private property requiring just compensation.

(b) Compliance reporting by chronic dialysis clinics.

(1) For each fiscal year starting on or after January 1, 2019, a governing entity shall maintain and submit to the department a report concerning all of the following information for all of the chronic dialysis clinics the governing entity owns or operates in California:

(A) The number of treatments performed.

(B) Direct patient care services costs.

(C) Health care quality improvement costs.

(D) Treatment revenue, including the difference between amounts billed but not yet paid and estimated realizable revenue.

(E) The fair treatment payment amount.

(F) The unfair excess charged amount.

(G) The amount, if any, of each payer's rebate, provided that any individual patient shall be identified using only a unique identifier that does not reveal the patient's name or identity.

(H) A list of payers to whom no rebate was issued pursuant to subparagraph (D) of paragraph (2) of subdivision (a) and the amount not issued, provided that any individual patient shall be identified using only a unique identifier that does not reveal the patient's name or identity.

(2) The information required to be maintained and the report required to be submitted by this subdivision shall each be independently audited by a certified public accountant in accordance with the standards of the Auditing Standards Board of the American Institute of Certified Public Accountants and shall include the opinion of that certified public accountant as to whether the information contained in the report fully and accurately describes, in accordance

with generally accepted accounting principles in the United States, the information required to be reported under paragraph (1).

(3) The governing entity shall annually submit the report required by this subdivision to the department on a schedule, in a format, and on a form prescribed by the department, provided that the governing entity shall submit the information no later than 210 days after the end of its fiscal year. The chief executive officer or other principal officer of the governing entity shall certify under penalty of perjury that he or she is satisfied, after review, that the report submitted to the department under paragraph (1) is accurate and complete.

(4) In the event the department determines that a chronic dialysis clinic or governing entity failed to maintain the information or timely submit a report required under paragraph (1) of this subdivision or paragraph (3) of subdivision (a), that the amounts or percentages reported by the chronic dialysis clinic or governing entity under paragraph (1) of this subdivision were inaccurate or incomplete, or that any failure by a chronic dialysis clinic or governing entity to timely issue in full a rebate required by subdivision (a) was not substantially justified, the department shall assess a penalty against the chronic dialysis clinic or governing entity not to exceed one hundred thousand dollars (\$100,000). The department shall determine the amount of the penalty based on the severity of the violation, the materiality of the inaccuracy or omitted information, and the strength of the explanation, if any, for the violation. Penalties collected pursuant to this paragraph shall be used by the department to implement and enforce laws governing chronic dialysis clinics.

(c) Definitions. For purposes of this section:

(1) "Direct patient care services costs" means those costs directly associated with operating a chronic dialysis clinic in California and providing care to patients in California. Direct patient care services costs shall include, regardless of the location where each patient undergoes dialysis, only (i) salaries, wages, and benefits of nonmanagerial chronic dialysis clinic staff, including all clinic personnel who furnish direct care to dialysis patients, regardless of whether the salaries, wages, or benefits are paid directly by the chronic dialysis clinic or indirectly through an arrangement with an affiliated or

unaffiliated third party, including but not limited to a governing entity, an independent staffing agency, a physician group, or a joint venture between a chronic dialysis clinic and a physician group; (ii) staff training and development; (iii) pharmaceuticals and medical supplies; (iv) facility costs, including rent, maintenance, and utilities; (v) laboratory testing; and (vi) depreciation and amortization of buildings, leasehold improvements, patient supplies, equipment, and information systems. For purposes of this section, "nonmanagerial chronic dialysis clinic staff" includes all clinic personnel who furnish direct care to dialysis patients, including nurses, technicians and trainees, social workers, registered dietitians, and nonmanagerial administrative staff, but excludes managerial staff such as facility administrators. Categories of direct patient care services costs may be further prescribed by the department through regulation.

(2) "Governing entity" means a person, firm, association, partnership, corporation, or other entity that owns or operates a chronic dialysis clinic for which a license has been issued, without respect to whether the person or entity itself directly holds that license.

(3) "Health care quality improvement costs" means costs, other than direct patient care services costs, that are related to the provision of care to chronic dialysis patients and that are actually expended for goods or services in California that are required to maintain, access, or exchange electronic health information, to support health information technologies, to train nonmanagerial chronic dialysis clinic staff engaged in direct patient care, and to provide patient-centered education and counseling. Additional costs may be identified by the department through regulation, provided that such costs are actually spent on services offered at the chronic dialysis clinic to chronic dialysis patients and are spent on activities that are designed to improve health quality and to increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

(4) "Payer" means the person or persons who paid or are financially responsible for payments for a treatment provided to a particular patient and may include the patient or other individuals, primary insurers, secondary insurers, and other

entities, including Medicare and any other federal, state, county, city, or other local government payer.

(5) “Treatment” means each instance when the chronic dialysis clinic provides services to a patient.

(6) “Treatment revenue” for a particular fiscal year means all amounts actually received and estimated realizable revenue for treatments provided in that fiscal year. Estimated realizable revenue shall be calculated in accordance with generally accepted accounting principles and shall be a reasonable estimate based on (i) contractual terms for patients covered under commercial healthcare plans with which the governing entity or clinics have formal agreements; (ii) revenue from Medicare, Medicaid, and Medi-Cal based on rates set by statute or regulation and estimates of amounts ultimately collectible from government payers, commercial healthcare plan secondary coverage, patients, and other payers; and (iii) historical collection experience.

SEC. 4. Section 1226.8 is added to the Health and Safety Code, to read:

1226.8. (a) A chronic dialysis clinic shall not discriminate with respect to offering or providing care, and shall not refuse to offer or provide care, to patients on the basis of the payer for treatment provided to a patient, including but not limited to on the basis that the payer is a patient, private payer or insurer, Medi-Cal, Medicaid, or Medicare.

(b) A chronic dialysis clinic shall not terminate, abridge, modify, or fail to perform under any agreement to provide services to patients covered by Medi-Cal, Medicaid, or Medicare on the basis of requirements imposed by this chapter.

SEC. 5. Section 1266.3 is added to the Health and Safety Code, to read:

1266.3. It is the intent of the people that California taxpayers not be financially responsible for implementation and enforcement of the Fair Pricing for Dialysis Act. In order to effectuate that intent, when calculating, assessing, and collecting fees imposed on chronic dialysis clinics pursuant to Section 1266, the department shall take into account all costs associated with implementing and enforcing Sections 1226.7 and 1226.8.

SEC. 6. Nothing in this act is intended to affect health facilities licensed pursuant to subdivision (a), (b), or (f) of Section 1250 of the Health and Safety Code.

SEC. 7. The State Department of Public Health shall issue regulations necessary to implement this act no later than 180 days following its effective date.

SEC. 8. Pursuant to subdivision (c) of Section 10 of Article II of the California Constitution, this act may be amended either by a subsequent measure submitted to a vote of the people at a statewide election, or by a statute validly passed by the Legislature and signed by the Governor, but only to further the purposes of the act.

SEC. 9. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

PROPOSITION 10

This initiative measure is submitted to the people in accordance with the provisions of Section 8 of Article II of the California Constitution.

This initiative measure repeals and adds sections to the Civil Code; therefore, existing provisions proposed to be deleted are printed in ~~strikeout type~~ and new provisions proposed to be added are printed in *italic type* to indicate that they are new.

PROPOSED LAW

The Affordable Housing Act

The people of the State of California do hereby ordain as follows:

SECTION 1. Title.

This act shall be known, and may be cited, as the “Affordable Housing Act.”

SEC. 2. Findings and Declarations.

The people of the State of California hereby find and declare all of the following:

(a) Rents for housing have skyrocketed in recent years. Median rents are higher in California than any other state in the country, and among all 50 states, California has the fourth highest increase in rents.