LEAGUE OF WOMEN VOTERS® OF CALIFORNIA EDUCATION FUND

PROPOSITION 29 – IN DEPTH SUPPLEMENT

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

Introduction

Prop 29 was placed on the ballot through the signature gathering process. This is third time a proposition on the subject of kidney dialysis clinics has appeared on the ballot. This version of the proposition is substantially similar to the one that appeared on the 2020 ballot.

Background

Patients with End Stage Renal Disease (ESRD) have kidneys that do not function well enough for the patient to survive without either a kidney transplant or ongoing dialysis. Dialysis is used to replicate kidney function and generally takes four hours per treatment three days per week. High blood pressure and diabetes are the main causes of chronic kidney disease in the U.S. The lives of patients on dialysis can be extended for years.

Roughly 80,000 Californians receive dialysis at one of 650 CDCs each month. Two private dialysis clinic operators, DaVita from Colorado and Fresenius Medical Care from Germany, own and operate approximately 72% of all clinics in the state. The remainder of the clinics are operated by a variety of nonprofit and for profit entities.

Payment for dialysis treatments comes from a variety of sources which are sometimes intertwined. Medicare pays for most treatments because federal law makes most patients with ESRD eligible regardless of age or disability status. However, if a patient has private group or individual insurance, the private insurance is the primary payer for the first 30 months of treatment.

Medi-Cal also covers dialysis treatments for patients who are indigent and have no other health insurance. In that case Medicare is the primary payer but Medi-Cal also pays a portion. These government programs set reimbursement rates for treatments, procedures, doctor visits, and other medical services. Those rates are largely set by regulation and are close to the average cost for treatment, which limits clinic operators' profit margins.

Private group and individual health insurance plans negotiate reimbursement rates with dialysis providers. On average, these groups pay multiple times what the government-funded programs do. As pointed out above, the private insurers generally

must pay for the first 30 months of treatment. After that time, Medicare covers the cost of dialysis.

Federal licensing regulations for dialysis clinics require that each patient be visited by his/her physician at the clinic at least once a month. There is also a federal requirement that each clinic employ a Medical Director who is a board-certified physician, a position that is estimated to be one-quarter time. That would imply that one physician could rotate as Medical Director among several different clinics. Reporting of patient infection data is required by the federal government.

The Proposal

Prop 29 would impose several requirements for CDC:

- They must have a physician, nurse practitioner or physician assistant on-site during all hours patients are receiving care, and that person must have at least 6 months of experience providing care to kidney patients. If there is a valid shortage of such persons the clinic may apply for an exception, which would last for one year. Telehealth must be utilized during that year.
- They must provide patients with a list of all physicians who have an ownership interest in the clinic of 5% or more. Every 3 months they must report to the state the name(s) of anyone having a 5% or more interest in the clinic. If they fail to provide the required data they could be fined up to $100,000.
- They must report dialysis-related infection data to state and federal governments.
- They must get approval from the state to close or reduce services.
- They may not discriminate against patients based on the source of payment for their care.

Previous Similar Propositions

Prop. 8 in November 2018 and Prop. 23 in November 2020 also dealt with dialysis clinics. All three propositions have several stipulations in common, such as that clinics may not discriminate against patients based on the source of payment. The big differences in Prop. 29 are the new requirement for reporting ownership interest in each clinic and the required use of telehealth when on-site staffing isn't available.

Props. 8 and 23, like this proposition, had the support of the SEIU-UHW West, a labor union for healthcare workers. They all reflect a conflict between the union and the state's two largest dialysis businesses, DaVita and Fresenius Medical Care. The union said workers at dialysis clinics have been attempting to unionize since 2016, but that their employers were retaliating against pro-union employees. Prop. 8 was defeated by a vote of 60% to 40% and Prop. 23 was defeated by a vote of 63% to 37%.

Note on Staffing Requirements

Only 8 states (Georgia, Maryland, Massachusetts, New Jersey, Oregon, South Carolina, Texas and Utah) and the District of Columbia have regulations mandating staffing ratios

in dialysis clinics. However, publicly available data on survival rates, rates of hospitalization and infection, and patient satisfaction are not superior in those states. California's outcomes are among the best in the United States. Almost 68% of California patients surveyed in 2018 rated their dialysis facility a nine or ten on a one to ten scale as opposed to 63% of patients in the states with mandated staffing ratios.

Fiscal Effects

If dialysis center owners/operators close clinics due to the cost of hiring a full-time physician, nurse practitioner, or physician assistant, the patients who use them will have to find dialysis elsewhere and may miss treatments, something that can lead to more hospitalization of such patients and higher costs to the state. The Legislative Analysis Office estimates that the cost to state and local governments could run into tens of millions of dollars annually. Since there would be increased administrative costs to the CA Dept. of Public Health due to the new reporting requirements, the department would be required to adjust the clinics' annual licensing fee to cover those costs, making the reporting requirement "budget neutral".

Supporters Say:

- Requiring a physician, nurse practitioner or physician assistant to be present during a dangerous procedure like dialysis is common sense and a matter of patient safety.
- Dialysis clinics may use telemedicine for up to a year if the required healthcare workers are not available.
- The big corporations operating dialysis clinics can easily make the required staffing changes and still profit hundreds of millions of dollars a year.

Opponents Say:

- Dialysis is administered by specially trained technicians and every dialysis patient is under the care of their own kidney doctor, so administrative oversight is unnecessary.
- Prop 29 would worsen our health care worker shortage, taking thousands of these individuals from hospitals where they're needed and placing them in administrative jobs.
- The unnecessary requirement for on-site administrators who do not provide patient care would cost hundreds of millions every year, forcing clinics to reduce hours or close.

***Supporters:** (signers of the ballot arguments are in bold)

Emanuel Gonzalez, Dialysis Patient Care Technician
Baptist Ministers Conference of Los Angeles
Cecilia Gomez-Gonzalez, Dialysis Patien Advocate
Richard Elliott, Dialysis Patient
Shama Aslam, Former Dialysis Patient
Richard Elliot, Dialysis Patient
Ruben Taedo, Dialysis Patient

Total from top contributors as of August 17, 2022 - $8,100,000

***Opponents:** (signers of the ballot arguments are in bold)

Anthony Hicks, Dialysis Patient
Angelic Nicole Gant, Dialysis Patient
Gregory Ridgeway, Dialysis Patient
American Nurses Association/CA
Margarita Mendoza, Dialysis Patient
California Medical Association

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Total from top contributors as of August 17, 2022 - $42,978,000

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