PALO ALTO ACCOUNTABLE AND AFFORDABLE HEALTH CARE INITIATIVE

SECTION 1. Chapter 5.40 is added to Title 5 of the Palo Alto Municipal Code, governing Health and Sanitation, to read:

Sec. 5.40.010 Purpose and intent.

It is the purpose and intent of this Chapter to provide for the orderly regulation of hospitals and other health facilities, as defined in this Chapter, in the interests of the public health, safety and welfare, by providing certain minimum standards and regulations regarding their operation. The prices charged to patients and other payers have far-reaching effects on consumers purchasing health care services and insurance, as well as taxpayers supporting public health and welfare programs. Investments in quality of care improvements can benefit patients and caregivers, and ultimately result in lower overall health care costs. For these reasons, and because neither the State nor federal governments have yet done so, this Chapter seeks to impose reasonable limits on prices that hospitals and other health facilities may charge and encourages further investment in health care quality improvements.

Sec. 5.40.020 Definitions.

For purposes of this Chapter the following terms have the following meanings:

(a) "Acceptable payment amount" means an amount equal to 115 percent of the sum of the reasonable cost of direct patient care for a particular patient and the pro rata health care quality improvement cost, or such amount determined by the Administrative Services Department pursuant to Section 5.40.030(d).

(b) "Amount reasonably estimated to be paid" means the payment amount specified by agreement between the hospital, medical clinic, or other provider, and the payer, or, in the absence of such an agreement, the amount of the bill or invoice for services.

(c) "Health care quality improvement costs" means costs a hospital, medical clinic, or other provider pays that are necessary to: maintain, access or exchange electronic health information; support health information technologies; train non-managerial personnel engaged in direct patient care; and provide patient-centered education and counseling. Additional costs may qualify as health care quality improvement costs, as authorized pursuant to Section 5.40.030(c).

(d) "Hospital" means a hospital within the meaning of subdivision (a) of Section 1250 of the California Health and Safety Code, but does not include: (1) any children's hospital identified in Section 10727 of the California Welfare and Institutions Code; (2) public hospitals, as defined in paragraph (25) of subdivision (a) of Section 14105.98 of the California Welfare and Institutions Code; or (3) hospitals operated by or licensed to the United States Department of Veterans Affairs.

(e) “Medical clinic” means a clinic within the definition of Section 1200 of the California Health and Safety Code, but does not include: (1) a chronic dialysis clinic, as defined by Section 1204(b)(2) of the California Health and Safety Code; (2) a clinic that provides services exclusively to children or operates under the license of a children’s hospital identified in Section 10727 of the California Welfare and Institutions Code; (3) community clinics or free clinics, as defined by Sections 1204(a)(1)(A) and (B) of the California Health and Safety Code; (4) clinics that primarily provide reproductive health care services, as defined in Section 6215.1 of the California Government Code, or family planning services, as defined by Section 14503 of the California Welfare and Institutions Code; (5) a clinic that is licensed to a county, a city, a city and county, the State of California, the University of California, a local health care district, a local health authority, or any other political subdivision of the state; or (6) a clinic operated by or licensed to the United States Department of Veterans Affairs.

(f) “Other provider” means any provider organization within the meaning of subdivision (f) of Section 1375.4 of the California Health and Safety Code, any risk-bearing organization within the meaning of subdivision (g) of Section 1375.4 of the California Health and Safety Code, and any outpatient setting within the meaning of Section 1248 of the California Health and Safety Code. Provided, however, that “other provider” shall not include: (1) a chronic dialysis clinic, as defined by Section 1204(b)(2) of the California Health and Safety Code; (2) an organization that provides services exclusively to children or operates under the license of a children’s hospital identified in Section 10727 of the California Welfare and Institutions Code; (3) community clinics or free clinics, as defined by Sections 1204(a)(1)(A) and (B) of the California Health and Safety Code; (4) clinics that primarily provide reproductive health care services, as defined in Section 6215.1 of the California Government Code, or family planning services, as defined by Section 14503 of the California Welfare and Institutions Code; (5) an organization owned by, operated by, or licensed to a county, a city, a city and county, the State of California, the University of California, a local health care district, a local health authority, or any other political subdivision of the state; or (6) an organization owned by, operated by or licensed to the United States Department of Veterans Affairs.

(g) “Payer” means the person or persons who paid or are financially responsible for payments for services provided to a particular patient, and may include the patient or other individuals, primary insurers, secondary insurers, and other entities, provided that the term does not include Medicare or any other federal, state, county, city, or other local government payer.

(h) “Pro rata health care quality improvement cost” means the total health care quality improvement costs paid by a hospital, medical clinic, or other provider in a fiscal year, divided by the total number of patients treated by that hospital, medical clinic, or other provider in the same fiscal year.

(i) “Reasonable cost of direct patient care” means the cost of providing care to a patient in a fiscal year, as provided for in Section 5.40.030(b)(1).

Sec. 5.40.030 Pricing limitations and rebates.

All hospitals, medical clinics, and other providers shall comply with the following requirements:

(a) Commencing January 1, 2019, a hospital, medical clinic, or other provider shall annually issue a rebate and a reduction in billed amount to a payer for all money paid or billed for services provided to a patient in excess of the acceptable payment amount for those services, as follows:

(1) No later than 150 days after the end of its fiscal year, a hospital, medical clinic, or other provider shall calculate its health care quality improvement costs and pro rata health care quality improvement cost for the most recently completed fiscal year.

(2) No later than 150 days after the end of its fiscal year, a hospital, medical clinic, or other provider shall compile the following information for each patient to whom it provided care in the most recently completed fiscal year:

(i) patient;

(ii) total amount received from each payer or payers for health care services provided in the fiscal year, or, if payment has not been made in full, the amount reasonably estimated to be paid by that payer or those payers for health care services provided in the fiscal year;

(iii) reasonable cost of direct patient care provided in the fiscal year;

(iv) acceptable payment amount for the fiscal year; and

(v) the amount, if any, by which the total amount identified pursuant to subparagraph (ii) exceeds the acceptable payment amount.

(3) No later than 180 days after the end of its fiscal year, a hospital, medical clinic, or other provider shall (i) issue a rebate of any amount paid, as described by subdivision (a)(2)(ii), in excess of the acceptable payment amount, and (ii) for any amount that has not been paid and for which the amount reasonably estimated to be paid exceeds the acceptable payment amount, as described by subdivision (a)(2)(ii), reduce the invoice to the acceptable payment amount and reissue the invoice to the payer.

(4) Where a rebate must be paid or an amount billed but not yet paid must be reduced pursuant to this section, and more than one payer is responsible, the hospital, medical clinic, or other provider shall divide and distribute the total required rebate or reduction in billed amounts among the payers consistent with the payers' relative obligations to pay for the services. The hospital, medical clinic, or other provider shall issue the rebate together with interest thereon at the rate of interest specified in subdivision (b) of Section 3289 of the California Civil

Code, which shall accrue from the date the hospital, medical clinic, or other provider received payment.

(5) Where, in any fiscal year, the rebate the hospital, medical clinic, or other provider must issue to a single payer is less than twenty dollars ($20), the hospital, medical clinic, or other provider need not issue that rebate.

(6) In the event a hospital, medical clinic, or other provider is required to issue a rebate or reduction in amount billed under this section, no later than 180 days after the end of its fiscal year the hospital, medical clinic, or other provider shall pay a fine to the Administrative Services Department for each patient for whom a rebate or reduction is required in the following amounts:

> (i) If rebates or reductions are owed by a hospital, medical clinic, or other provider for services provided to 50 patients or fewer in the fiscal year, an amount equal to five percent of the required rebate or reduction, provided that the fine for each rebate or reduction shall be at least one hundred dollars ($100), but shall not exceed one thousand dollars ($1,000) per rebate or reduction.
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> (ii) If rebates or reductions are owed by a hospital, medical clinic, or other provider for services provided to more than 50 patients in the fiscal year, an amount equal to 10 percent of the required rebate or reduction, provided that the fine for each rebate or reduction shall be at least one hundred dollars ($100), but shall not exceed one thousand dollars ($1,000) per rebate or reduction.

(7) In the event a hospital, medical clinic, or other provider fails to issue a rebate or reduction within the time required by paragraph (3), consistent with Municipal Code Section 1.08.010(d) each subsequent day that the required rebate or reduction is not issued constitutes a separate violation for which a fine is to be imposed pursuant to paragraph (6).

(8) Fines collected pursuant to paragraphs (6) and (7) shall be used by the Administrative Services Department to implement and enforce laws governing hospitals, medical clinics, and other providers.

(9) Where reimbursement for health care services is subject to the requirements of Section 1371.31(a) of the California Health and Safety Code, nothing in this Chapter shall affect the reimbursements required by that Section. Further, (i) the payments received for health care services that are subject to the reimbursement requirements of Section 1371.31(a) of the California Health and Safety Code shall not be included in the total amount received, or the total amount reasonably estimated to be paid, for the fiscal year pursuant to subdivision (a)(2)(ii), and (ii) the costs associated with providing health care services that are subject to the reimbursement requirements of Section 1371.31(a) of the California Health and

Safety Code shall not be included in the reasonable cost of direct patient care for the fiscal year pursuant to subdivision (a)(2)(iii).

(b) (1) No later than 150 days after the end of its fiscal year, every hospital, medical clinic, or other provider shall provide to the Administrative Services Department information identifying the reasonable cost of direct patient care for each patient to whom services were provided in the fiscal year. The reasonable cost of direct patient care shall be the reasonable costs directly associated with operating a hospital, medical clinic, or other provider in Palo Alto and providing care to patients in Palo Alto. The reasonable cost of direct patient care shall include only (i) salaries, wages, and benefits of non-managerial hospital, medical clinic, or other provider staff, including all personnel who furnish direct care to patients, regardless of whether the salaries, wages, or benefits are paid directly by the hospital, medical clinic, or other provider, 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 hospital, medical clinic, or other provider, and a physician group; (ii) staff training and development; (iii) pharmaceuticals and 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 paragraph, "non-managerial hospital, medical clinic, or other provider staff" includes all personnel who furnish direct care to patients, including doctors, nurses, technicians and trainees, social workers, registered dietitians, environmental service workers, and non-managerial administrative staff, but excludes managerial staff such as facility administrators. Categories of costs of direct patient care may be further prescribed by the department through regulation.

(2) Each hospital, medical clinic, or other provider shall maintain and report to the Administrative Services Department the information described in paragraph (1) of this subdivision, the information described in paragraph (1) of subdivision (a), and information describing every instance during the period covered by the submission when the rebate or reduction required under subdivision (a) was not timely issued in full, and the reasons and circumstances therefor. The information required to be maintained and the report required to be submitted by this paragraph shall each be independently audited by a certified public accountant in accordance with the standards of the Accounting 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.

(3) Each hospital, medical clinic, or other provider shall annually submit the report required by paragraph (2) of this subdivision on a schedule, in a format, and on a form prescribed by the Administrative Services Department, provided

that the hospital, medical clinic, or other provider shall submit the report no later than 150 days after the end of its fiscal year.

(4) The chief executive officer or administrator of the hospital, medical clinic, or other provider shall personally certify under penalty of perjury that he or she is satisfied, after review, that all information submitted to the department pursuant to paragraph (2) of this subdivision is accurate and complete.

(5) The Administrative Services Department shall annually publish information showing the number and aggregate amount of rebates provided, as well as the number and aggregate amount of fines paid, by each hospital, medical clinic, or other provider. Any information that must be reported to or by the Department pursuant to this Chapter shall be made available to the public upon request, consistent with the requirements of the California Public Records Act and any other applicable law, including limitations on public disclosure in the interest of personal privacy.

(c) (1) A hospital, medical clinic, or other provider may petition the Administrative Services Department at any time for a determination that a cost not specified in Section 5.40.020(c) is a health care quality improvement cost or for a determination that a cost not specified in Section 5.40.030(b)(1) is a reasonable cost of direct patient care.

(2) The Administrative Services Department may grant a petition concerning health care quality improvement costs only upon finding that the hospital, medical clinic, or other provider has demonstrated:

(i) The cost was spent on activities designed to improve health quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements;

(ii) The hospital, medical clinic, or other provider actually paid the cost; and

(iii) The cost was spent on services offered at the hospital, medical clinic, or other provider to patients.

(3) The Administrative Services Department may grant a petition concerning reasonable costs of direct patient care only upon finding that the hospital, medical clinic, or other provider has demonstrated:

(i) The cost was directly associated with operating a hospital, medical clinic, or other provider in Palo Alto and providing care to patients in Palo Alto and is reasonable in light of market rates for similar goods or services;

(ii) The hospital, medical clinic, or other provider actually paid the cost; and

(iii) The cost was spent on services offered at the hospital, medical clinic, or other provider to patients.

(4) The Administrative Services Department may permit the hospital, medical clinic, or other provider to apply a cost incurred in one year equally over a period not to exceed five years upon finding that the hospital, medical clinic, or other provider has demonstrated that the cost is reasonably expected to provide health care quality improvements or support direct patient care during that period.

(d) (1) A hospital, medical clinic, or other provider may petition the Administrative Services Department at any time for a determination that the acceptable payment amount defined in Section 5.40.020(a) should be increased with respect that hospital, medical clinic, or other provider.

(2) The Administrative Services Department may grant such a petition only upon finding that an acceptable payment amount of 115 percent of the sum of the reasonable cost of direct patient care and the pro rata health care quality improvement cost would be confiscatory or otherwise unlawful as applied to that hospital, medical clinic, or other provider.

(3) If the Administrative Services Department grants a petition pursuant to subdivision (d)(2), it may adjust the number "115" in Section 5.40.020(a) to the lowest whole number such that the resultant acceptable payment amount would not be unlawful. The Administrative Services Department shall not increase the acceptable payment amount to any amount greater than that minimally necessary under California and federal law. Any variance granted pursuant to subdivision (d) shall be for a period of one fiscal year, unless the petitioner demonstrates that a variance is likely to be required for subsequent fiscal years, in which case the Department may grant a variance for up to five years.

(4) In a petition pursuant to subdivision (d), the burden shall be on the hospital, medical clinic, or other provider to (i) prove that an acceptable payment amount of 115 percent of the sum of the reasonable cost of direct patient care for a particular patient and the pro rata health care quality improvement cost would be unlawful, and (ii) provide the Administrative Services Department with all information necessary to determine the lowest acceptable payment amount required by law.

Sec. 5.40.040 Implementation and Enforcement.

(a) The Administrative Services Department shall be authorized to coordinate implementation and enforcement of this Chapter and shall promulgate appropriate guidelines, regulations or rules for such purposes consistent with this Chapter. Such guidelines, regulations or rules shall ensure that implementation of this Chapter is consistent with the requirement of due process imposed by the California and United States Constitutions and, as necessary, shall provide guidance concerning the process for bringing a petition under this Chapter with the goals of minimizing the burden to the petitioner and increasing the efficiency of the petition review process. Any guidelines,

regulations or rules promulgated by the department shall have the force and effect of law. The City shall appropriate to the Administrative Services Department sufficient funds to enable the department to implement and enforce this Chapter.

(b) If a determination of a violation has been made, consistent with the requirements of due process, and except where prohibited by state or federal law, the department may request that City agencies or departments revoke or suspend any registration certificates, permits or licenses held or requested by the violator until such time as the violation is remedied. All City agencies and departments shall cooperate with revocation or suspension requests from the department. A violation of this Chapter may also be grounds for denying a hospital, medical clinic, or other provider a business license under Municipal Code Section 4.04.140(a)(5).

(c) Violation of this Chapter shall be a misdemeanor. The department, the City Attorney, any person aggrieved by a violation of this Chapter, any entity a member of which is aggrieved by a violation of this Chapter, or any other person or entity acting on behalf of the public as provided for under applicable state law, may bring a civil action in a court of competent jurisdiction against a hospital, medical clinic, or other provider violating this Chapter, or against the City for *de novo* review of a determination pursuant to Section 5.40.030(c) or (d), and, upon prevailing, shall be entitled to such legal or equitable relief as may be appropriate including, without limitation, twice the amount of the required rebate or reduction up to the maximum amount allowable by law and injunctive relief, and shall be awarded reasonable attorneys' fees and expenses. Provided, however, that any person or entity enforcing this Chapter on behalf of the public as provided for under applicable state law shall, upon prevailing, be entitled only to equitable, injunctive or restitutionary relief, and reasonable attorneys' fees and expenses. Nothing in this Chapter shall be interpreted as restricting, precluding, or otherwise limiting a separate or concurrent criminal prosecution under the Municipal Code or state law. Jeopardy shall not attach as a result of any administrative or civil enforcement action taken pursuant to this Chapter.

Sec. 5.40.050 Severability.

The provisions of this Chapter are severable. If any provision of this Chapter 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.