

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

#	FROM	COMMENT	DEPARTMENT RESPONSE
1-1	Talia Leon Inland Empire Health Plan	<p>(b) "Organization" means a risk-bearing organization as defined in Health and Safety Code Section 1375.4(g). An organization includes a entity that contracts directly with the plan or subcontracts with another organization to arrange for the health care services of a plan's enrollees and meets the other requirements of Health and Safety Code section 1375.4(g).</p> <p>Comment - "Clarification is requested as to whether a health plan will be responsible for conducting assessments on all sub-delegates that contract with an RBO. Or are such assessments of an RBO sub-delegates the responsibility of the RBO?"</p>	<p>No specific change requested. Thank you for your comment.</p> <p>Health and Safety Code section 1367 provides that the obligations of a health plan to comply with the Knox-Keene Act is not waived when the health plan delegates any services it is required to perform. Additionally, section 1375.4 of the Health and Safety Code requires every contract between a health care service plan and an organization shall have specific provisions relating to the organization's administrative and financial capacity. Under the terms of the regulation, a sub-delegate has the same requirements as an organization under the Knox-Keene Act.</p>
1-2	Talia Leon Inland Empire Health Plan	<p>(f) "Cash-to claims ratio" is an organization's cash, readily available marketable securities and <u>plan</u> receivables due within 30 days, excluding all risk pool, risk sharing, incentive payment and pay for performance receivables, reasonably anticipated to be collected within 60 days divided by the organization's unpaid claims (claims payable and incurred but not reported [IBNR] claims) liability.</p> <p>Comment - The plans recommend that a breakdown of HMO Receivable-Net, and any other receivable account on the Balance Sheet that records plan receivables, be broken down by</p>	ACCEPTED. The DMHC has made the proposed amendment to the regulation.

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		"collectible within 30 days", and "collectible beyond 30 days".	
1-3	Talia Leon Inland Empire Health Plan	<p>(1)(A) Quarterly Financial survey report <u>information</u> (including balance sheet, an income statement, and a statement of cash flows, a statement of net worth, cash and cash equivalent, receivables and payables, risk pool and other incentives, claims aging, notes to financial statements, enrollment information, mergers, acquisitions and discontinued operations, the incurred but not reported (IBNR) methodology and administrative expenses), or in the case of a nonprofit entity comparable financial</p> <p>Comment - As Schedule B - Receivables on pages 42 and 60 do not include a column for <=30 Days, the plans recommend that one be added to appropriately reflect the Balance Sheet item "HMO Capitation Receivable-Net (collectible within 30 days)" that is provided on pages 37 and 55.</p>	ACCEPTED. The DMHC has made the proposed amendment to the regulation.
1-4	Talia Leon Inland Empire Health Plan	<p><u>That excludes unsecured affiliate receivables except those arising in the normal course of business which are payable on the same terms as equivalent transactions with non-affiliates.</u></p> <p>Comment - If Schedule B is the only form that provides visibility into an RBO's receivables, clarification is requested on how unsecured affiliate receivables, that arise through the normal course of business, can be identified to properly calculate an RBO's TNE?</p>	ACCEPTED. The DMHC has made the proposed amendment to the regulation.
1-5	Talia Leon	(c) The organization has failed Failed to	No specific change requested. Thank you for

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

	Inland Empire Health Plan	<p>substantially comply with the requirements of a final CAP for a period of more than 90 days, as determined by the Department.</p> <p>Comment - "Feedback is requested in relation to instances where there is not a specific reference to working/business/calendar days. Is it to be assumed in such instances that the Department requirements are defaulted to ""calendar"" days? "</p>	<p>your comment.</p> <p>Under the law, when there is no specific reference to working/business/calendar days the reference is interpreted to be "calendar" days.</p>
1-6	Talia Leon Inland Empire Health Plan	<p>(c) Unless, within 45 7 calendar days of the receipt of an organization's self initiated CAP proposal, a contracting health plan or sub-delegating organization provides written notice to the Department and the risk-bearing organization state the reason for its objections and recommendations for revisions, the self initiated CAP shall be considered a final CAP subject to approval by the Department subject to the Department's approval process as set forth in sections (g) and (h) below.</p> <p>Comment - The plans recommend that the existing 15 day notice requirement be preserved to ensure that impacted entities have sufficient time to review and if needed respond to a CAP proposal.</p>	ACCEPTED. The DMHC has made the proposed amendment to the regulation.
1-7	Talia Leon Inland Empire Health Plan	<p>(1)Effective one-year after the operative date of this amended section, for the purposes of this section, "positive tangible net equity" that an organization, as defined in Health and Safety Code section 1375.4(g), shall be at least equal to the greater of: (A) one percent (1%) of annualized revenues; or (B) four percent (4%) of annualized non-capitated medical expenses.</p>	<p>No specific change requested. Thank you for your comment.</p> <p>The DMHC has revised Schedule I of its annual and quarterly forms to delete the reference to "minimum TNE."</p> <p>As noted in the comment, the proposed regulation defines "positive tangible net equity"</p>

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		<p>Comment - a) Clarification is requested as to whether "positive tangible net equality" should or should not include "minimum TNE" .</p> <p>b) In relation to the question above, clarification is also requested on how DMHC will determine a Minimum TNE requirement?</p> <p>c) Feedback is requested as to whether the new TNE requirement could result in RBOs incurring less costs in providing enrollee care and/or on administrative costs in processing timely claims.</p>	<p>to be at least equal to the greater of: (A) one percent of the annualized revenues; or (B) four percent of the annualized non-capitated medical expenses. All organizations must comply with the requirements starting one year after the operative date of the proposed amendments. Each organization will be required to comply with the proposed regulation while ensuring financial solvency and compliance with the existing organization regulations and statutes. However, reaching compliance with the proposed TNE will depend on the specific circumstances of each organization and the DMHC is not regulating the internal process of how each organizations reach solvency compliance.</p>
2-8	<p>Catrina Reyes, Esq.</p> <p>California Medical Association (CMA)</p>	<p>On behalf of our more than 43,000 physician and medical student members, the California Medical Association (CMA) would like to thank you for considering comments on the Department of Managed Health Care’s (hereinafter “the Department”) proposed regulations to ensure the financial solvency of risk-bearing organizations pursuant to Health & Safety Code § 1375.4.</p> <p>CMA supports the Department’s endeavors to ensure that risk-bearing organizations are financially solvent and are able to take on the weight of their risk-based agreements. Oversight of organizations that assume responsibility for the health care services and the financial liability for health plan enrollees should be the same regardless of whether</p>	<p>No specific change requested. Thank you for your comment.</p>

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		<p>the organization contracts directly with the health plan or subcontracts with another organization. Without such oversight, the stability of the health care delivery system could be negatively impacted and the delivery of health care to patients disrupted. If organizations are financially insolvent, it would result in patients having to be transferred to other organizations for health care services thereby interrupting their care. This is especially a concern for Medi-Cal patients that have more limited options. Moreover, provider claims will not be paid which then impacts their financial viability and exacerbates the disruptions in health care delivery. As the recent experiences with Vantage Medical Group and Nivano show, oversight of risk-bearing organizations is necessary to allow the Department to properly monitor financials to spot deficiencies and correct them before they negatively impact the health care marketplace and patients. Oversight is especially critical given that the Department has seen an increase in the number of organization-to-organization risk-shifting arrangements and the current regulations do not address the oversight of these sub-delegated organizations.</p>	
2-9	<p>Catrina Reyes, Esq. California Medical Association (CMA)</p>	<p>CMA also supports the Department’s efforts to balance the need to ensure financial solvency and oversight with the need to minimize the disparate impact on smaller organizations that may have difficulty meeting the financial standards and complying with the reporting requirements. Ensuring financial solvency includes ensuring that health plans are paying timely and adequate capitated</p>	<p>No specific change requested. Thank you for your comment.</p>

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		<p>rates. Moreover, protecting the financial viability of smaller organizations as well as their ability to meet financial solvency requirements is of importance so as to avoid artificially encouraging smaller organizations to consolidate or be acquired. Costs of complying with regulations tend to fall disproportionately on smaller organizations and when smaller organizations are unable to comply with regulatory requirements they are incentivized to consolidate into larger groups thereby compromising competition. As such, CMA broadly recommends that the Department continually assess the impacts of the proposed regulations on the health care market to ensure that market competition is maintained or enhanced. Ensuring competition in the market promotes high quality, accessible, and affordable care.</p> <p>We appreciate your consideration of our input and look forward to working with the Department and other stakeholders to ensure it achieves its objectives.</p>	
3-10	<p>Brianna Lierman, Esq.</p> <p>Local Health Plans of California (LHPC)</p>	<p>The Local Health Plans of California (LHPC) represents all 16 of the community-based and not-for-profit health plans that collectively cover 70% of California’s 10.6 million Medi-Cal managed care beneficiaries. Local health plans were created to be mission-driven health plans closely connected to the communities that established them, with nearly all local health plans being public entities.</p> <p>We believe the Department of Managed Health Care’s</p>	<p>No specific change requested. Thank you for your comment.</p>

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		(Department) proposed regulations enhancing reporting requirements for risk-bearing organizations (RBOs) and their sub-delegates advance the important objectives of increased transparency and accountability in the health care delivery system. We have minimal comments on these regulations as follows:	
3-11	Brianna Lierman, Esq. Local Health Plans of California (LHPC)	Corrective Action – 1300.75.4.8 The Department is proposing to revise Section (c) to give plans 7 instead of 15 days to object to an RBO’s self-imposed corrective action before it is treated as final. Receipt, review and response to a delegates’ corrective action is an involved process often involving multiple plan departments. Plans request that the Department retain the original 15-day time frame so plans can continue to have the time necessary to exercise thoughtful oversight of their delegates and devise adequate responses to corrective actions.	ACCEPTED. Please see the response to comment #1-6.
3-12	Brianna Lierman, Esq. Local Health Plans of California (LHPC)	Balance Sheet The plans recommend that a breakdown of HMO Receivable-Net (and any other receivable account on the Balance Sheet that records plan receivables) be broken down by "collectible within 30 days" and "collectible beyond 30 days".	ACCEPTED. Please see the response to comment #1-2.
3-13	Brianna Lierman, Esq. Local Health Plans of California	Schedule B Receivables does not include a column for <30 Days. Health plans recommend that one be added to appropriately reflect the Balance Sheet item "HMO Capitation Receivable-Net (collectible within 30 days)"	ACCEPTED. Please see the response to comment #1-3.

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

	(LHPC)	(pages 37 and 55). Thank you for considering local health plans' comments on the proposed regulation enhancing reporting requirements for RBOs and their subdelegates.	
4-14	Anthony Wright Health Access California	Health Access California, the statewide health care consumer advocacy coalition working for affordable and quality health care for all Californians, offers comments on the department's rulemaking action on the subject of Financial Solvency of Risk Bearing Organizations, Control No. 2017-5216. Health Access supports the general intent of the proposed regulation changes, but we also note areas where the regulations could be strengthened.	No specific change requested. Thank you for your comment.
4-15	Anthony Wright Health Access California	Fiscal solvency and network adequacy are among the most basic consumer protections offered by the Knox-Keene Act. Indeed, it was the lack of fiscal solvency, failure to contract with providers and lack of basic management by some Medi-Cal managed care that precipitated the enactment of the Knox-Keene Act in 1975. Similarly, the failure of delegated medical groups in the mid-1990's precipitated the enactment of SB 260 (Speier) of 1999. These failures resulted not only in bankruptcies for physicians but lack of access to medical records for consumers as well as disruptions of care. SB 260 created the current indirect regulatory structure in which contracting medical groups and other entities accepting delegation of risk are regulated through licensed health plans rather than directly by the Department. Before the Financial Solvency Standards Board began its work, and the Department began to	No specific change requested. Thank you for your comment.

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		<p>establish regulations for the delegated groups, very large enterprises--some managing care for hundreds of thousands of consumers-- lacked such basic management tools as audited financial reports and business plans that are necessary for the provision of timely access to care without inappropriate delays or denials.</p> <p>The cease-and-desist order issued by the Department to a number of health plans in late December, 2017, with regard to denials of care by EHS/SynerMed, including the exclusion of cardiologists, oncologists, rheumatologists, dialysis and other specialists, again demonstrates the importance of financial solvency and network adequacy as essential consumer protections.</p> <p>Consumers should get the care they need when they need it: that is the promise of the Knox- Keene Act and these regulations further clarify steps needed to assure these protections are realized. Health Access offers these comments to assure adequate consumer protections.</p>	
4-16	<p>Anthony Wright</p> <p>Health Access California</p>	<p>Authority and Reference:</p> <p>In addition to the citations noted in the statement of reasons, Health Access points to the final sentence of Health and Safety Code 1367, which was added by SB 639 (Hernandez), c. 316 of 2013, legislation sponsored by Health Access:</p> <p>“The obligation of the plan to comply with this <i>chapter</i> shall not be waived when the plan delegates <i>any services</i> that it is required to perform to its</p>	<p>No specific change requested. Thank you for your comment.</p>

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		<p>medical groups, independent practice associations, or other contracting entities.”</p> <p>The plain language of this provision extends the requirement to comply with this “chapter,” that is the Knox-Keene Act, to any contracting entity, whether delegated or sub-delegated.</p>	
4-17	<p>Anthony Wright</p> <p>Health Access California</p>	<p>Comments on Proposed Regulations</p> <p>As it pertains to the following proposed amendments, Health Access California provides the following comments:</p> <ul style="list-style-type: none"> - <i>Applying the definition of a risk-bearing “organization” as an “entity that contracts directly with a health care service plan or arranges for health care services for the health care service plan’s enrollees” (1300.75.4 (a)) to “sponsoring organization” (1300.75.4 (j)) and “sub-delegating organization.” (1300.75.4 (k))</i> <p>● Health Access supports this application of definition because it ensures that such entities comply with important Knox-Keene Act consumer protections, especially financial solvency standards and requirements. Financial solvency requirements not only affect operations and transaction of plans and plan-affiliates, and plan-provider and provider-affiliate contractual relationships, they also deeply affect the delivery of health care services to consumers.</p>	<p>No specific change requested. Thank you for your comment.</p>
4-18	Anthony Wright	<ul style="list-style-type: none"> ● A contracting entity that is not financially solvent 	<p>No specific change requested. Thank you for</p>

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

	Health Access California	may deny or delay medically necessary care to enrollees. This most often arises initially as lack of access to appropriate specialists and specialty but may even result in lack of access to primary care and hospitalization or medically necessary drugs. Financial solvency is one of the most basic consumer protections provided under insurance regulation to assure that enrollees receive medically necessary care in return for premiums paid by themselves or on their behalf by an employer or a public program.	your comment. The DMHC will continue to monitor these delegated arrangements and ensure compliance with the Knox-Keene Act, including access to medically necessary care, for all enrollees.
4-19	Anthony Wright Health Access California	<p>- <i>Clarifying what “positive tangible net equity” (TNE) is for the purpose of calculating the TNE of a risk-bearing “organization” is to be compliant with the Solvency Regulations defined by Section 1300.76.</i></p> <ul style="list-style-type: none"> o The proposed regulation would require a TNE requirement of the greater of 1% of annualized revenue or 4% of annualized non-capitated medical expenses. While this is an improvement over the current standard, it is not sufficient to assure financial solvency in the face of expected risk. Health Access requests a change in the requirement of “positive tangible net equity” that requires the “organization” to keep sufficient reserves that amounts to, at a minimum, 60 to 90 days of the current claims liabilities. 	DECLINED. The DMHC arrived at the proposed language following extensive research on the use of various methodologies to obtain TNE. The DMHC believes the proposed language balances the need of the health plans and the protection of consumers.
4-20	Anthony Wright Health Access California	<p>Application of “Organization” Definition to “Sponsoring Organization” and “Sub-Delegating Organization”</p> <p>The Department’s proposal to apply the full definition</p>	No specific change requested. Thank you for your comment. The DMHC will continue to monitor these delegated arrangements and ensure compliance with the Knox-Keene Act and to update its regulations as necessary to

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		<p>of a risk-bearing organization to sponsoring and sub-delegating organizations will assure that the Department oversees such organizations in the same way that the Department oversees other risk-bearing organizations (organizations that contract directly with health plans). Because of the complexity of delegation and sub-delegation, the existing financial solvency regulations need to be updated to assure that no health plan escapes accountability by creating multiple layers of delegation. The final provision of Health and Safety Code Section 1367 assures that the plan retains responsibility for complying with the Knox-Keene Act, no matter how complex the delegation or sub-delegation of responsibilities.</p>	<p>ensure compliance with the law.</p>
4-21	<p>Anthony Wright Health Access California</p>	<p>The changes to the definition and requirements for a sponsoring organization as well as the sunset on the term of a sponsoring organization also further clarify the regulations to assure that a sponsoring organization is fiscally able to meet its obligations and that the role as a “sponsor” is not a permanent one. Before the regulations on risk-bearing organizations were initiated after the enactment of SB 260 in 1999, numerous medical groups and independent practice associations were in financial peril and suffered from a lack of basic management capacity. For instance, medical groups each responsible for care for hundreds of thousands of lives and millions of dollars of delegated care lacked management tools as basic as routine financial audits, something which was remedied by the Department in the first months of its existence. The</p>	<p>No specific change requested. Thank you for your comment.</p>

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		definition of sponsoring organization dates to those early days of regulating risk-bearing organizations. It is appropriate that it be reviewed and updated in light of the experience of the Department over the last 15 years. A “sponsoring organization” should not be a subterfuge for avoiding appropriate regulatory oversight: the proposed changes to the regulations give the Department better oversight in such circumstances.	
4-22	Anthony Wright Health Access California	The proposed changes to the regulations authorize the Department to obtain important financial, enrollment, and other information from sponsoring and sub-delegating organizations that contract with licensed health plans or arrange health care services of a health plan’s enrollees. Additionally, the proposed changes would permit the Department to require these organizations abide by specific financial standards to assure that such organizations have sufficient resources to pay and provide health care services to enrollees. The changes also permit the Department to require contracting health plans to impose corrective action plans on delegated entities that contract with sponsoring and sub-delegating organizations that do not meet the requirements of these regulations and other provisions of the Act.	No specific change requested. Thank you for your comment.
4-23	Anthony Wright Health Access California	Network adequacy is a fundamental consumer protection and is inextricably linked to an organization’s financial solvency. Once a provider group and/or health plan begins to restrict access to providers in order to reduce costs, consumers are negatively affected because care is delayed or denied. For example, in the recent enforcement	No specific change requested. Thank you for your comment. The DMHC will continue to monitor these delegated arrangements and ensure compliance with the Knox-Keene Act, including the adequacy of provider networks.

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		<p>action against numerous health plans that contracted with Employee Health Services Medical Group, which delegated medical management to SynerMed, found that SynerMed had “narrowed” its network by denying enrollees access to specialists including cardiology, diagnostic radiology, dialysis, hematology, oncology, ophthalmology and rheumatology. This is a classic managed care failure in which consumers are denied timely access to medically necessary care in order to mask the lack of an adequate network and maintain the financial solvency of an organization accepting capitation payments.</p>	
4-24	<p>Anthony Wright</p> <p>Health Access California</p>	<p>Compliance with Block Transfer Requirements</p> <p>The regulations appropriately include a requirement that a sub-delegating organization comply with block transfer requirement, if applicable. The block transfer requirements in H&S 1373.65 were adopted in 2003 and thus post-date the adoption of SB 260 in 1999 and its ensuing regulations which were largely adopted in 2000-2002. We appreciate the Department thinking through the implications of a sub-delegated entity transferring plan enrollees to alternative providers as a result of financial difficulties.</p>	<p>No specific change requested. Thank you for your comment. The DMHC will continue to monitor these delegated arrangements and ensure compliance with the Knox-Keene Act, including block transfer requirements and adequacy of networks.</p>
4-25	<p>Anthony Wright</p> <p>Health Access California</p>	<p>Positive Tangible Net Equity Requirements of Risk-Bearing Organizations</p> <p>The Department’s proposed change with respect to “positive tangible net equity” (TNE) for purposes of calculating the TNE of a risk-bearing “organization”</p>	<p>No specific change requested. Thank you for your comment.</p> <p>Section 1300.75.4.8 requires organizations reporting deficiencies in any grading criteria to simultaneously submit a self-initiated CAP</p>

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		<p>is not sufficient to assure an adequate reserve.</p> <p>Health and Safety Code Section 1375.4 says that the director shall adopt regulations that provide for “a process for reviewing or grading risk-bearing organizations based on the following criteria” which include that the risk bearing organization “maintains at all times a positive level of working capital (excess of current assets over current liabilities)”. However, the law does not say what grade should be assigned to those organizations which meet criterion 4. Nothing in the law specifies what grade is to be given to an organization that meets criterion 4. From our perspective as consumer advocates, and given research done concurrently with the development of the original regulations, we suggest that an organization which meets criterion 4 be given a flunking grade and required to improve its solvency to a more adequate level.</p>	<p>proposal. Section 1300.75.4.4 requires all organizations, when applicable, show that the organization has met or not met each of the grading criteria when submitting their financial survey forms. The organizations must also disclose whether they have implemented and are compliant with a final CAP designed to remedy deficiencies reported in the grading criteria. The proposed annual and quarterly survey reports also specifically ask for information relating to TNE, working capital, cash-to-claims ratio, claims and IBNR for the grading criteria portion.</p>
4-26	Anthony Wright Health Access California	<p>At a minimum, those organizations that meet only criterion 4 should be subject to closer scrutiny than those that meet criterion 3. We suggest that the department review the track record of those groups that meet only criterion 4 to determine how often over the last 15 years, groups meeting this minimal criterion for financial solvency required corrective action plans or other interventions to assure financial solvency and protect access to care.</p>	<p>No specific change requested. Thank you for your comment.</p> <p>Please see the response to comment #4-25.</p>
4-27	Anthony Wright Health Access California	<p>The regulations in effect today merely require a positive TNE requirement that is equal to or greater than \$1. This is completely insufficient. It exposes both consumers and physicians to undue financial</p>	<p>No specific change requested. Thank you for your comment. The Department has closely considered how to define and monitor TNE sufficiency and what qualifies as positive TNE.</p>

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		<p>risk. An enrollee risks lack of access to timely and medically necessary care if a group faces financial difficulties that exhaust the single dollar of reserves. In a typical instance of lack of financial solvency, enrollees facing life-threatening health care needs can find themselves denied referrals to specialists, admission to hospitals, necessary tests, or necessary outpatient medications. The physicians who are partners in the medical group are equally exposed if a group faces significant financial risk. In the mid-1990s, some physicians faced personal bankruptcy as a result of the insolvency of delegated groups. While this has not occurred frequently since, a solitary dollar is a thin margin of financial reserves.</p>	<p>The Department made the policy decision of what can be determined positive TNE for the purposes of the regulation after considerable thought and review of financial procedures.</p>
4-28	<p>Anthony Wright Health Access California</p>	<p>Consumers are told that they should have three to six months of living expenses in reserve in case of financial emergencies such as the loss of employment or illness of themselves or a family member. Consumers are expected to fund such emergency reserves out of post- tax dollars with no preferential tax treatment. While some claim that physician groups are unable to muster adequate reserves because of tax treatment of physician incomes, we are skeptical that this is a valid reason for exposing consumers, and indeed physicians themselves, to the risks of a lack of an adequate reserve.</p>	<p>No specific change requested. Thank you for your comment.</p>
4-29	<p>Anthony Wright Health Access California</p>	<p>The proposed requirement for positive tangible net equity of the greater of 1% of annualized revenue or 4% of annualized non-capitated medical expenses is an improvement over the current requirement of \$1 but it is not sufficient. A reserve of 1% of revenue</p>	<p>DECLINED. Please see the response to comment #4-19.</p>

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		<p>would get burned through in a few days. Health Access requests a change in the requirement of “positive tangible net equity” that requires the “organization” to keep reserves that amount to 60 to 90 days of the current claims liabilities. It generally takes 60-90 days for the physician to generate a claim, for the provider “organization” to process the claim, and then for the “organization” to pay the physician.¹ The “organization” should keep sufficient TNE to cover the claims normally accrued in a period.</p> <p style="text-align: center;"><small>¹ California Physician Solvency Group Standards, California Health Care Foundation, August 2002.</small></p>	
4-30	Anthony Wright Health Access California	<p>As a response to the failures of risk-bearing provider organizations, FPA Medical Management and MedPartners, in the late 1990’s, Health Access California supported SB 260 (Speier, Chaptered 1999), which established minimal financial solvency standards, timelines for claims payments, general guidelines for claims liability calculation, and reporting requirements to risk-bearing provider organizations. The legislation also created the Financial Solvency Standards Board to provide the Director advise on financial solvency matters that affect the delivery of health care services. While we supported SB 260, we also recognize its policy shortcomings especially in a changing health care system and a California-specific health care system that operates under a highly capitated model and that is highly delegated, where risk has not only been delegated, but also further sub-delegated to various provider group and provider-affiliated</p>	No specific change requested. Thank you for your comment.

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		<p>management entities.</p> <p>A study² commissioned by the California Health Care Foundation in 2002 concurrent with the development of the SB260 regulations found that SB 260 standards were flawed from the start. For example, FPA would have passed the standards merely months before its bankruptcy filing (See Table 1-1) since SB 260 standards simply required risk-bearing/capitated provider organizations to have a positive working capital and TNE – literally at least \$1. The current SB 260 standards as implemented in regulations today, do not address the cash-flow cycle for capitated provider organizations. The nature of the cash-flow cycle generally takes 60-90 days from when the service is rendered by the physician to the patient, physician makes a claim, the provider organization processes the claim, then makes payment to the physician. Given this cash-flow timeline, it is practical and realistic to require risk-bearing organizations to have 60-90 days-worth of TNE.</p> <hr style="width: 20%; margin-left: 0;"/> <p>² Ibid.</p>	
4-31	Anthony Wright Health Access California	A provider group’s ability to cover its current liabilities is measured by comparing its cash-on-hand to its current claims liabilities. Cash-on-hand generally represents a significant portion of its current liabilities and should equal or exceed claims liabilities. Since many capitated provider groups did not have sufficient cash to cover their current	DECLINED. Please see the response to comment #4-19.

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		<p>liabilities as seen in FPA and MedPartners failures, a cash to current liabilities ratio may prove to be a better ratio and a strong predictor of insolvency for California provider groups.³ This ratio, coupled with a minimum time duration requirement of either 60 or 90 days, could be considered as an additional regulatory standard for California provider groups by the Department.</p> <hr style="width: 30%; margin-left: 0;"/> <p>³ Ibid.</p>	
4-32	<p>Anthony Wright</p> <p>Health Access California</p>	<p>Conclusion</p> <p>Health Access California appreciates the DMHC’s continued work in protecting consumers’ health care rights and ensuring a stable health care delivery system. This includes assuring that Knox-Keene Act rules are appropriately amended related to financial solvency standards and reporting requirements of risk-bearing organizations. In doing so, the DMHC will safeguard consumers’ fundamental rights of access to medically necessary care.</p> <p>Health Access California respectfully requests that the DMHC consider these comments. Thank you for your consideration.</p>	No specific change requested. Thank you for your comment.
5-33	<p>Wendy Soe</p> <p>California Association of Health Plans</p>	<p>The California Association of Health Plans (CAHP) represents 48 public and private health care service plans that collectively provide coverage to over 25 million Californians. We appreciate the opportunity to comment on this rulemaking pertaining to financial solvency requirements for Risk Bearing</p>	ACCEPTED. Please see the response to comment #1-2.

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		<p>Organizations (RBOs).</p> <p>1300.75.4(f) “Cash-to-claims ration” is an organization’s cash, readily available marketable securities and <u>plan receivables due within 30 days, excluding all risk pool, risk sharing, incentive payment and pay-for-performance receivables, reasonably anticipated to be collected within 60 days</u> divided by the organization’s unpaid claims (claims payable and incurred but not reported [IBNR] claims) liability.</p> <p>We recommend that a breakdown of “HMO Receivable-Net”, and any other receivable account on the Balance Sheet that records plan receivables, be broken down by “collectible within 30 days” and “collectible beyond 30 days”.</p>	
5-34	Wendy Soe California Association of Health Plans	<p>1300.75.4.2(b)(1)(A) Quarterly F<u>financial survey report information (including a balance sheet, an income statement, and a statement of cash flows, a statement of net worth, cash and cash equivalent, receivables and payables, risk pool and other incentives, claims aging, notes to financial statements, enrollment information, mergers, acquisitions and discontinued operations, the incurred but not reported (IBNR) methodology and administrative expenses)</u>, or in the case of a nonprofit entity comparable financial statements and supporting schedule information...</p>	ACCEPTED. Please see the response to comment #1-3.

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		We recommend that a column for <=30 days be added to “Schedule B – Receivables” to appropriately reflect the Balance Sheet item “HMO Capitation Receivable-Net” (collectible within 30 days).	
5-35	Wendy Soe California Association of Health Plans	1300.75.4.2(b)(4)(D)(1) A statement as to whether or not the organization at all times during the quarter maintained positive TNE...and has at all times during the quarter maintained positive working capital, calculated in a manner consistent with GAAP, <u>that excludes unsecured affiliate receivables except those arising in the normal course of business which are payable on the same terms as equivalent transactions with non- affiliates...</u> If Schedule B is the only form that provides visibility into an RBO’s receivables, we recommend clarification on how unsecured affiliate receivables that arise through the normal course of business, can be identified for calculation of an RBO’s TNE.	ACCEPTED. Please see the response to comment #1-4.
5-36	Wendy Soe California Association of Health Plans	1300.75.4.5(a)(2)(C) The organization has failed <u>Failed</u> to substantially comply with the requirements of a final CAP for a period of more than 90 days, as determined by the Department. Where it is not specified whether 90 days refers to weekdays or calendar days, is the default “calendar” days?	No specific change requested. Thank you for your comment. Where calendar or workday is not specified, under the law it is considered to be a calendar day.
5-37	Wendy Soe California	1300.75.4.8(c) Unless, within <u>45 7 calendar</u> days of the receipt of an organization’s self-initiated CAP proposal, a contracting health plan	ACCEPTED. Please see the response to comment # 1-6.

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

	Association of Health Plans	<p><u>or sub-delegating organization provides written notice to the Department and the risk bearing organization stating the reason for its objections and recommendations for revisions, the self-initiated CAP shall be considered a final CAP subject to approval by the Department, subject to the Department’s approval process as set forth in sections (g) and (h) below.</u></p> <p>We recommend that the existing 15 day notice requirement be preserved to ensure that impacted entities have sufficient time to review and if needed, respond to a CAP proposal.</p>	
5-38	Wendy Soe California Association of Health Plans	<p>1300.76(c)(1) Effective one-year after the operative date of this amended section, for the purposes of this section, “positive tangible net equity” that an organization, as defined in Health and Safety Code section 1375.4(g):</p> <p>(A) one percent (1%) of annualized revenues; or (B) four percent (4%) of annualized non-capitated medical expenses.</p> <p>We seek clarification as to whether or not “positive tangible net equity” should include “minimum TNE”. We also seek additional clarification as to how DMHC determines minimum TNE.</p> <p>Thank you the opportunity for offer comment to these proposed regulations.</p>	<p>No specific change requested. Thank you for your comment.</p> <p>As noted in the comment, the proposed regulation defines “positive tangible net equity” to be at least equal to the greater of: (A) one percent of the annualized revenues; or (B) four percent of the annualized non-capitated medical expenses. All organizations must comply with the requirements starting one year after the operative date of the proposed amendments. Each organization will be required to comply with the proposed regulation while ensuring financial solvency and compliance with the existing organization regulations and statutes. However, reaching compliance with the proposed TNE will depend on the specific circumstances of each organization and the DMHC is not regulating</p>

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

			the internal process of how each organizations reach solvency compliance.
6-39	Bill Barcellona America's Physician Groups	<p>America's Physician Groups represents over 180 risk bearing organizations across California that are directly affected by this proposed regulation. Thank you for the opportunity to provide written comment.</p> <p>General comments. APG commends the Department on the successful implementation and ongoing operation of the financial solvency monitoring structure over the past decade. We are appreciative of the work performed by Department staff during this time and we are also proud of our member organizations for their compliance, solvency and contribution to affordability and access in the California health care system.</p> <p>We support the continued use of the Financial Solvency Standards Board as an important vehicle to encourage discussion about the evolving health care market place, and the quarterly transparent reporting of the financial health of risk bearing organizations. We believe that this level of transparency contributes to the superior performance of this delivery system model.</p>	No specific change requested. Thank you for your comment.
6-40	Bill Barcellona America's Physician Groups	<p>Analysis of Closures Due to Financial Problems. Cattaneo & Stroud have tracked the closures of capitated medical groups and IPAs with 6 or more physicians since 1997, collecting and supplementing information obtained from Department of Corporations and DMHC filings. From 1997 to 2016 they report the closure of 313 organizations, with 103 of those groups closed for</p>	No specific change requested. Thank you for your comment.

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		<p>financial problems, equating to 33%.ⁱ The majority of closures occurred between 1997 to 2003, before the full implementation of the statute by regulation. Between 2004 and 2016 only 8 RBOs have closed due to financial problems, an average of less than 1 per year. Of those 8, we have compiled the annual tracking by year, number and size of the group as follows:</p>	
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DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

Year	No. of Groups Closed	Group Size by Lives	Primary Line of Business
2004	0		
2005	1	17,300	Multiple
2006	0		
2007	0		
2008	1	3,900	Medi-Cal
2009	0		
2010	2	5,500 & 4,400	Medi-Cal
2011	1	1,700	Medi-Cal
2012	1	3,100	Medi-Cal
2013	1	4,050	Medi-Cal
2014	1	41,600	Medi-Cal
2015	0		
2016	1	1,050	Medi-Cal
Total/Ave.	9	<6,000 for 8 of 10 closures	Medi-Cal

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		<p>Risk-bearing organizations accept capitated payments under three major programs – commercial HMO, Medicare Advantage and Medi-Cal managed care. Over time, commercial enrollment within the RBO community has significantly decreased from approximately 10 million lives to about 3.5 million.ⁱⁱ However, even with that contraction, groups that primarily served commercial enrollees did not suffer financial hardship to any great degree. We note that over the past decade the clear majority of the RBOs falling under watch list scrutiny and corrective action plans have been those concentrated in the Medi-Cal managed care sector of the market. The overall performance of the risk-bearing-organization community has been relatively stable since 2004, however the table indicates that RBOs primarily associated with Medi-Cal risk are the most likely to fail.</p>	
6-41	<p>Bill Barcellona America's Physician Groups</p>	<p>The Financial Impact of Proposed Rule on RBOs: In this proposed amendment of the financial solvency regulation the Department appears to intend that the administrative capacity of an RBO, especially a self-delegating RBO, should be comparable to a fully-licensed Knox Keene Health Care Service Plan, since it is requiring the same time deadlines for compliance with downstream transmission of information, completion of CAP submittals, etc. Risk-Bearing Organizations do not have the staff or administrative capacity of their contracted health plan partners. Requiring them to acquire such administrative infrastructure will be costly and will add to the bottom line of their administrative overhead. We seek clarification from the Department concerning its assessment of this</p>	<p>No specific change requested. Thank you for your comment. The Department has started the reasoning behind the amendments to the existing regulations in this rulemaking package in both the Notice of Rulemaking as well as the Initial Statement of Reasons.</p>

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		tradeoff, given the historical lack of significant RBO closures over the past decade. We wish to note that one unintended consequence of the addition of quarterly requirements to RBOs smaller than 10,000 lives could be the further consolidation of the number of RBOs in the market place and resultant loss of competition in certain regions.	
6-42	Bill Barcellona America's Physician Groups	1300.75.4: The Definitions section of the proposed rule does not provide a definition of "affiliate." Some members asked how an "affiliate" may differ from a sponsoring organization relationship. We request that the Department clarify how it currently characterizes affiliate relationships and whether it intends any changes in the proposed rule.	DECLINED. Section 1300.45, subdivision (c), already defines "affiliate" as a person controlled by, under common control with, or controlling such person. A person's relationship with another person is that of an "affiliated person" if such other person, director, trustee, or a member of its executive committee or other governing board or committee, or that of an officer or general partner, or holds any other position involving responsibility and authority similar to that of a principal officer or general partner; or who is the holder of 5 percent or more of its outstanding equity securities; or who has any such relationship with an affiliate of such person. An affiliate is also an affiliated person.
6-43	Bill Barcellona America's Physician Groups	1300.75.4(f): Many of our members commented that the limitation under the cash-to-claims ratio definition to receivables due within 30 days would be problematic. They commented that there are many instances when solid receivables lag beyond 30 days, such as in the case of cap withholds that require clarification, and P4P payments. APG suggests that 60 calendar days is a more feasible	DECLINED. The 30-day receivables change is necessary for the DMHC to determine an organizations ability to pay claims and demonstrate financial solvency. The receivables due beyond 30 days are only reasonably anticipated to be paid at a later date and does not accurately reflect readily available funds available to the organization to pay

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		time frame to reflect the solvency of the organization. Moreover, the definition does not clarify whether these are calendar or business days. We assume that the department intended calendar days according to the common rules of construction.	claims and remain solvent.
6-44	Bill Barcellona America's Physician Groups	<p>1300.75.4.1(a)(1-3): The 10-day electronic transmission deadline at page 2 of the Text, subsection (a)(2) may not be workable. Both the plan and the sub-delegating organization have 10 days to transmit the information downstream to the sub-contracted entity. It is common for a capitated-delegated RBO to receive the eligibility and cap files from its contracted plans randomly from the 1st through the 12th of each month. When the files are received the RBO has to resolve deficiencies in the files before it loads the data into their system. It usually takes three business days to complete this process for each contracted health plan. The DMHC Statement of Organization details how many plan contracts are held by each RBO. ⁱⁱⁱ The typical range is between 6 to 12 individual plan contracts. Turnaround times would be very tight for most organizations. Moreover, the current language of the proposed rule requires clarification by the Department. One member wrote:</p> <p><i>“As far as eligibility, we get one eligibility load from the health plan, and we know that there are changes during the month, but we don't get that load from the health plan until the following month, so how can we provide that to the sub-delegated RBO (changes) if we don't have that? I believe the answer under the</i></p>	<p>PARTIALLY ACCEPTED. The DMHC as revised section 1300.75.4.1(a)(1)-(2) to now allow for 15 calendar days for the disclosure through electronic transmission.</p> <p>PARTIALLY DECLINED. The commenter requested “at least five additionally business days.” (Emphasis added). The existing language allows 10 calendar days for the disclosure through electronic transmission. The DMHC has extended this requirement by five calendar days and not five business days, which is sufficient to obtain the information requested.</p>

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		<p><i>proposed rule is that once you receive the supplemental “changes” file, you have to transmit it within the first 10 days of the following month. Is that the intended standard?”</i></p> <p>APG requests clarification of the Department’s intent, and suggests that the proposed rule is modified to require sequential deadlines from the plan to the sub-delegating RBO to the sub-delegated RBO of at least five additional business days upon receipt of the supplemental files from the health plan.</p>	
6-45	<p>Bill Barcellona</p> <p>America’s Physician Groups</p>	<p>1300.75.4.1(a)(4)(A): The matrix of responsibility for medical expenses includes existing language that includes “<u>physician</u>, institutional, ancillary, and pharmacy.” The term of art in the industry to distinguish capitated risk categories is “professional” rather than “physician” such as “professional and institutional risk” when referring to a global cap arrangement. One member suggested that this change would provide greater clarity and consistency with current contractual usage.</p>	<p>DECLINED. The term “professional” rather than a physician may lead to potential confusion as the term “professional” encompasses all professionals including nurses, attorneys, accountants and so forth. The term “professional” is broad and may lead to an erroneous interpretation. Physician is an understood term in the medical industry.</p>
6-46	<p>Bill Barcellona</p> <p>America’s Physician Groups</p>	<p>1300.75.4.1(c): Capitated payment disclosures are required to be expressed in “the amount to be paid per enrollee per month.” The proposed rule requires disclosure of capitated arrangements under Medicare Advantage, which are more commonly made under percentage of premium (POP) than per-member-per-month (PMPM), and this distinction is recognized elsewhere in the proposed rule by the Department. It will be extremely difficult and time-consuming to attempt to convert POP to an equivalent PMPM and could result in</p>	<p>ACCEPTED. The DMHC has made the proposed amendment to the regulation.</p>

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		<p>unintended errors in the calculation. We suggest that the Department amend the proposed rule to recognize the distinction by adding the following text to the end of the sentence: "...the amount to be paid per enrollee per month, <u>or the respective amount under a percentage of premium arrangement.</u>"</p>	
6-47	<p>Bill Barcellona America's Physician Groups</p>	<p>1300.75.4.2(a): One of our members commented that the Cash-to-claims ratio was initially required to be .60 during the first six months of operation as an RBO, which was then changed to .75 in 2007. APG requests the Department to clarify whether it intends to implement a .75 ratio at all times, including the first six months.</p>	<p>No specific change requested. Thank you for your comment.</p> <p>Section 1300.75.4.2(a) provides, "[e]ffective one year from the operative date of this amended section, maintain at all times a minimum "cash-to-claims ratio as defined in section 1300.75.4(f) of 0.75. During the one (1) year phase-in period, an organization shall comply with the cash-to-claims ratio definition as required by the DMHC the year immediately prior to the effective date of this amended section."</p> <p>In section 1300.75.4.2(a)(1), it is noted that beginning on January 1, 2006, the minimum cash-to-claim ratio shall be 0.65 and beginning on January 1, 2007 and thereafter the minimum cash to claims ratio shall be 0.75.</p> <p>Accordingly, since January 1, 2007, the cash to claims ratio has been and will continue to be 0.75. In fact, in the proposed regulation, the DMHC is proposing to strike out section 1300.75.4.2(a)(1) as it is no longer needed and</p>

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

			may cause confusion.
6-48	Bill Barcellona America's Physician Groups	1300.75.4.2(b)(1)(B): Please clarify whether an RBO reporting on a combining basis with an affiliate organization would need to adjust for affiliate receivables if the affiliate is included in the consolidation (as a subsidiary), since the affiliate receivable is eliminated in the first place. If this is not the case, APG suggests that the Department add clarifying language to this subsection to this effect. The same issue would be apparent in the annual filing requirement as well.	DECLINED. By definition, all intercompany transactions are eliminated upon consolidation/combination. If this is not the case, then the reporting RBO will need to adjust for affiliate receivables.
6-49	Bill Barcellona America's Physician Groups	1300.75.4.2(b): The successive numbering after (b)(4) is confusing. It appears that the added subsections (a), (b) and (c) at the end of subsection (b)(4) follow (4)(A)(i)(ii). Our comment refers to these added subsections near the bottom of page 6 of the text. In the proposed added text, the Department has provided very good flexibility around the 1 year provision. Our members commented that any organization that needed a sponsor would likely need them through the entire first payer contracting cycle, which is more often 2-3 years, and not one year. If in the future Department staff took a literal, strict constructionist view of this added provision, we suggest that virtually every sponsoring organization relationship would need to seek an exception under the rule. That appears cumbersome and inefficient. We suggest that the proposed language be modified beyond 1 year to accommodate the "initial payer contracting cycle, or whichever is longer."	DECLINED. The DMHC reviewed the successive numbering and finds it to be in compliance and in order necessary to number the regulations and to comply with existing numbering of the regulations. The proposed requirements for sponsoring organizations are necessary to clarify that an organization may not rely indefinitely on a sponsoring organization to meet its financial requirements. The proposed amendment clarifies that an organization may use a sponsoring organization's guarantee for one fiscal year and may request from the DMHC an extension of up to one additional year. This gives the DMHC a means to enforce the financial solvency criteria of organizations and maintain marketplace stability.
6-50	Bill Barcellona America's Physician	Finally, we wish to incorporate by reference the comments filed by the California Association of Health Plans with the Department.	No specific change requested. Thank you for your comment.

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

	Groups	<p>Thank you for the opportunity to provide written comment. Please contact us should you wish to discuss our comments further.</p> <p>Endnotes:</p> <hr style="width: 20%; margin-left: 0;"/> <p>ⁱ www.cattaneostroud.com. Table 2A – List of Closed Medical Groups in Descending Yearly Quarters. Sourced on July 7, 2018 at: http://cattaneostroud.com/wp-content/uploads/2017/05/2A-Web.pdf. Page 55.</p> <p>ⁱⁱ Excluding the Permanente Medical Group enrollment figures within Kaiser Foundation Health Plan.</p> <p>ⁱⁱⁱ http://wps0.dmhc.ca.gov/ProviderReports/statorg.aspx.</p>	
6-51	Bill Barcellona America's Physician Groups	<p>The 10-day electronic transmission deadline at page 2 of the Text, subsection (a)(2) may not be workable. Both the plan and the sub-delegating organization have 10 days to transmit the information downstream to the sub-contracted entity. But if the RBO receives it on the 10th day from the plan, it is unlikely that it can pass it along to the sub-delegated entity on the same day. Particularly if it needs to clarify the information with the Plan. I don't know whether you've considered adding on an additional time-frame for downstream transmission. I think that would be practical.</p>	<p>No specific change requested. Thank you for your comment.</p> <p>Please see response to comment #6-44. The existing language allows 10 calendar days for the disclosure through electronic transmission. The DMHC has extended this requirement by five calendar days and not five business days, which is sufficient to obtain the information requested.</p>
6-52	Bill Barcellona America's Physician Groups	<p>A further clarification on this topic: "As far as eligibility, we get one eligibility load from the HP, and we know that there are changes during the month, but we don't get that load from the HP until the following month, so how can we provide that toe the sub-delegated RBO (changes) if we don't have that?"</p>	<p>No specific change requested. Thank you for your comment.</p> <p>Please see response comment #6-44. The existing language allows 10 calendar days for the disclosure through electronic transmission.</p>

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		I believe the answer under the proposed rule is that once you receive the supplemental “changes” file, you have to transmit it within the first 10 days of the following month. Is that the intended standard?	The DMHC has extended this requirement by five calendar days and not five business days, which is sufficient to obtain the information requested.
6-53	Bill Barcellona America’s Physician Groups	One of my members commented that the Cash-to-claims ratio was initially .60 during the first six months, which was then changed to .75 in 2007. He was confused whether the proposed change by the Department would implement a .70 ratio at all times, including the first six months. Can you clarify the Department’s current practice?	<p>No specific change requested. Thank you for your comment.</p> <p>Please see response to comment #6-47. Section 1300.75.4.2(a) provides, “[e]ffective one year from the operative date of this amended section, maintain at all times a minimum “cash-to-claims ratio as defined in section 1300.75.4(f) of 0.75. During the one (1) year phase-in period, an organization shall comply with the cash-to-claims ratio definition as required by the DMHC the year immediately prior to the effective date of this amended section.”</p> <p>In section 1300.75.4.2(a)(1), it is noted that beginning on January 1, 2006, the minimum cash-to-claim ratio shall be 0.65 and beginning on January 1, 2007 and thereafter the minimum cash to claims ratio shall be 0.75.</p> <p>Accordingly, since January 1, 2007, the cash to claims ratio has been and will continue to be 0.75. In fact, in the proposed regulation, the DMHC is proposing to strike out section 1300.75.4.2(a)(1) as it is no longer needed and may cause confusion.</p>
6-54	Bill Barcellona	Some members asked whether “affiliate” has been	No specific change requested. Please see

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

	America's Physician Groups	defined anywhere, and how it may differ from a sponsoring organization relationship. Since that is also a current issue, not limited to the proposed regulation, could we discuss how the Department characterizes current affiliate relationships so that I can provide some explanation to the APG membership?	response to comment #6-42. Affiliate is already defined in the Knox-Keene Act and it is not necessary to duplicate its existing definition.
6-55	Bill Barcellona America's Physician Groups	The issue of the reporting matrix at page 3, subsection (A) that includes “physician, institutional, ancillary, and pharmacy” – the term of art in the industry to distinguish capitated risk is “professional” rather than “physician” such as “professional and institutional risk” when referring to a global cap arrangement. One member commented that this change would provide greater consistency with current contractual usage.	DECLINED. Please see response to comment #6-45.
6-56	Bill Barcellona America's Physician Groups	At the top of page 3, “in the case of capitated payment, the amount to be paid per enrollee from any capitation payment...” Reporting under a pmpm structure when a RBO is actually under a percentage of premium capitated arrangement with a plan. Percentage of premium is used extensively in California Medicare Advantage arrangements, but is also legal in Medi-Cal Managed Care subsequent to enabling legislation that is about 5 years old. We didn't know how the Department currently requires Plans to report under this provision when they use POP versus PMPM. Could you fill us in?	ACCEPTED. The DMHC has made the proposed amendment to the regulation for clarification.
6-57	Bill Barcellona America's Physician	Many groups commented on the 30-day receivables change. They commented that there are many instances when solid receivables lag beyond 30 days, such as in the case of cap withholds that	No specific change requested. Thank you for your comment. Please see response to comment #6-43.

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

	Groups	require clarification, and P4P payments. They felt that 60 days was a more feasible time frame to reflect the solvency of the organization.	
6-58	Bill Barcellona America's Physician Groups	Finally, I received comments on the sponsoring organization 1 year guarantee provision. The Department has provided very good flexibility around the 1 year provision, in my opinion. Some commenters thought that any organization that needed a sponsor would likely need them through the entire first payer contracting cycle, which is more often 2-3 years, and not one year. I think your language provides the flexibility to accommodate that if good cause is shown in the application, however, some Department staff could, in the future, take a more literal, strict constructionist, interpretation of the provision.	No specific change requested. Thank you for your comment. Please see response to comment #6-49.
6-59	Bill Barcellona America's Physician Groups	The preferred use of the industry term “professional” rather than “physician” in the reference to elements of capitated payment at the top of page 3 of the regulation text at subsection (A). A discrepancy in the filing information on capitated payments at page 4, subsection (c) where it specifies how to report PMPM elements to the Department. Unfortunately, since a RBO must report on Medicare Advantage business, as well as commercial HMO and Medi-Cal MMC, most Medicare Advantage contracts are structured under percentage of premium capitation, not pmpm, and thus, the required information would be a square peg to fit in a round hole. I shared that problem with CAHP this morning and asked for input from the MA Plans. Michelle and Pritika may have already figured out a solution.	No specific change requested. Thank you for your comment. Please see response to comment #6-45 and comment # 6-46.

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

6-60	Bill Barcellona America's Physician Groups	  <p style="text-align: center;">Proposed DMHC RBO Regulation</p> <p style="text-align: center;">Summary Presented by Bill Barcellona June 27, 2018</p> <p style="text-align: center;">Agenda</p> <ul style="list-style-type: none">12:00: Overview of the Proposed Regulation, Application, Changes from Prior Practice12:15: Addition of SB 260 Compliance to Sub-Delegating Organizations12:25: Responsibilities of Sub-Delegated Organizations12:45: Additional Standards Applicable to all Delegating Entities1:00: Wrap-Up, Next Steps1:05: Question and Answer1:30: Adjourn <p>Phone lines will be muted during the presentation until the Q&A session, but you will have a "chat" function available at all times to submit live questions through the webex</p> 	No specific change requested. Thank you for your comment.
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DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

Overview of the Proposed Rule

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Regulations are also referred to as "rules" and are set forth in Title 28 of the California Code of Regulations (Title 28 provides regulations for the Knox Keene Act)

This proposed regulation applies to section 1375.4 of the Knox Keene Act, which is commonly referred to as the "SB 260 law." It is intended to clarify broad language in statute, and provide specific process and procedures, like filing forms.

The DMHC publishes proposed, "open-pending" regulations on its web site at: <http://wpso.dmhc.ca.gov/regulations/#1>.

This proposed regulation has three parts:

- The Notice – explains time frames and the process for public comment
- The Text – contains the substance of the proposed rule to be adopted, the legal language
- The Initial Statement of Reasons – cites the sections covered, and explains the intent behind and basis of any changes or additions that the Department is proposing

AMERICA'S
PHYSICIAN
GROUPS

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

6-61

Bill Barcellona

America's
Physician
Groups

No specific change requested. Thank you for your comment.

Sections in the Text of the Regulation

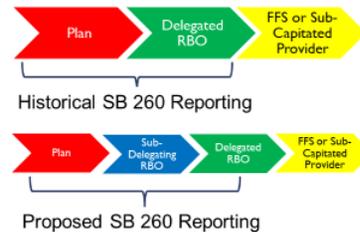
Section	Pages	Topical Content
1300.75.4	1-2	Definitions
1300.75.4.1	2-4	Risk Arrangement Disclosure
1300.75.4.2	4-11	Organization Information
1300.75.4.5	11-13	Plan and Sub-Delegating Organization Compliance
1300.75.4.7	13-14	Organization Evaluation
1300.75.4.8	14-17	Corrective Action
1300.76	18-19	Plan Tangible Net Equity Requirement
Form	20-25	Corrective Action Plan Form
Form	26-40	Quarterly Financials Reporting (w/ Schedules A-J)
Form	41-58	Annual Financial Survey Report (w/ Schedules A-J)

Disclaimer: The opinions expressed in this presentation are preliminary, based upon the reading of the proposed regulation. DMHC has neither confirmed or denied the interpretation of its intent during this initial comment period

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ADDs: SUB-DELEGATING RBO COMPLIANCE

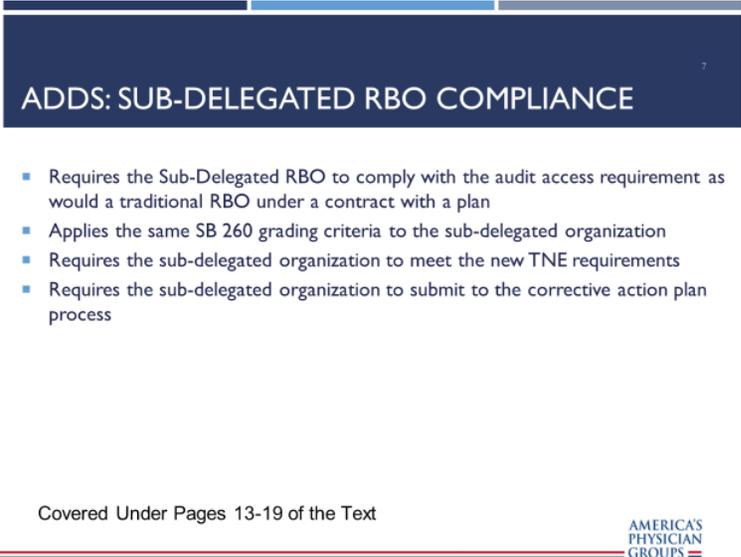
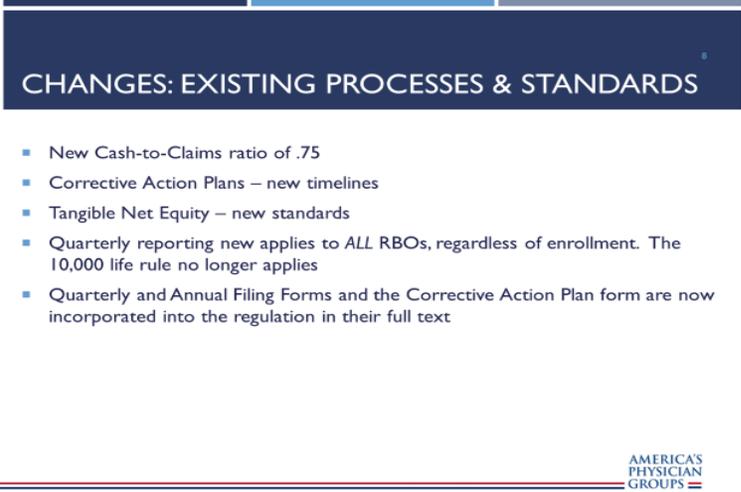
- Applies the same rules that require plans to disclose and require compliance to their delegated RBOs to the relationship between a sub-delegating RBO and its delegated RBO:



Covered Under Pages 2-13 of the Text

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GROUPS

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

<p>6-62</p>	<p>Bill Barcellona</p> <p>America's Physician Groups</p>	 <p>ADDS: SUB-DELEGATED RBO COMPLIANCE</p> <ul style="list-style-type: none"> ■ Requires the Sub-Delegated RBO to comply with the audit access requirement as would a traditional RBO under a contract with a plan ■ Applies the same SB 260 grading criteria to the sub-delegated organization ■ Requires the sub-delegated organization to meet the new TNE requirements ■ Requires the sub-delegated organization to submit to the corrective action plan process <p>Covered Under Pages 13-19 of the Text</p> <p style="text-align: right;"><small>AMERICA'S PHYSICIAN GROUPS</small></p>	<p>No specific change requested. Thank you for your comment.</p>
<p>6-63</p>	<p>Bill Barcellona</p> <p>America's Physician Groups</p>	 <p>CHANGES: EXISTING PROCESSES & STANDARDS</p> <ul style="list-style-type: none"> ■ New Cash-to-Claims ratio of .75 ■ Corrective Action Plans – new timelines ■ Tangible Net Equity – new standards ■ Quarterly reporting now applies to ALL RBOs, regardless of enrollment. The 10,000 life rule no longer applies ■ Quarterly and Annual Filing Forms and the Corrective Action Plan form are now incorporated into the regulation in their full text <p style="text-align: right;"><small>AMERICA'S PHYSICIAN GROUPS</small></p>	<p>No specific change requested. Thank you for your comment.</p>

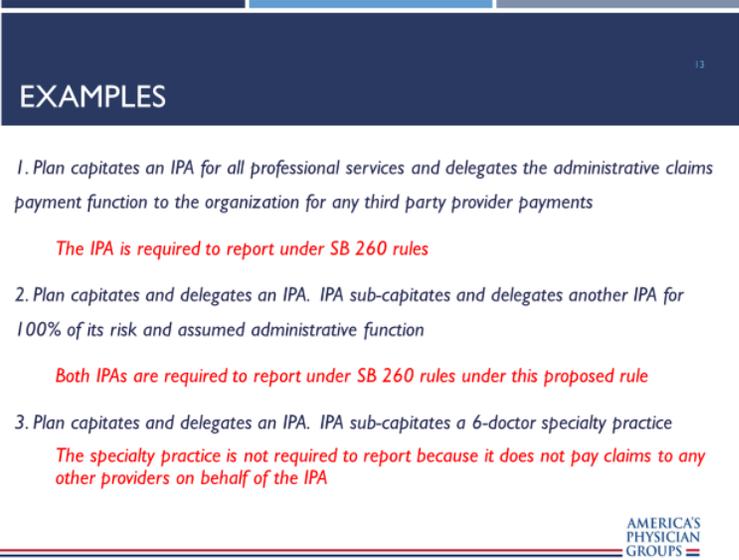
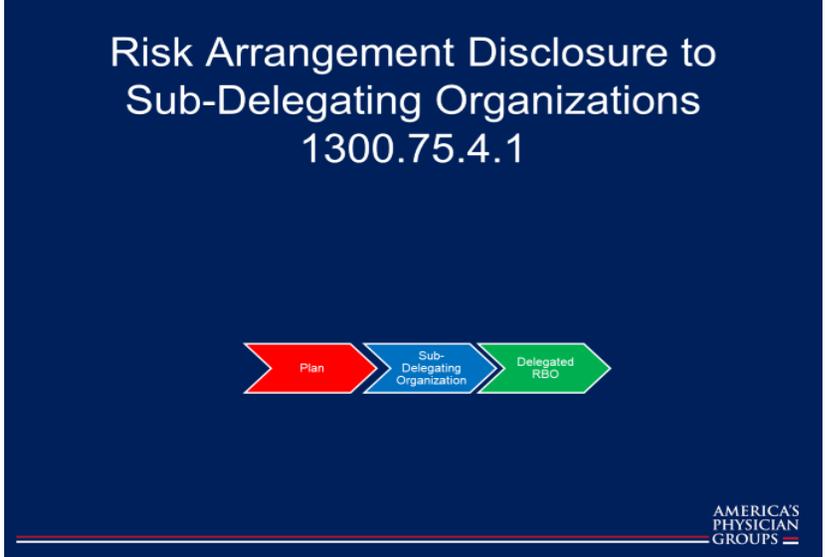
DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

<p>6-64</p>	<p>Bill Barcellona</p> <p>America's Physician Groups</p>	<p align="center">Addition of SB 260 Compliance to Sub-Delegating Organizations and Their Delegated RBOs</p> <p align="center">AMERICA'S PHYSICIAN GROUPS</p>	<p>No specific change requested. Thank you for your comment.</p>
<p>6-65</p>	<p>Bill Barcellona</p> <p>America's Physician Groups</p>	<p align="center">WHAT IS AN "RBO" UNDER 1375.4?</p> <ul style="list-style-type: none"> ■ The Knox Keene Act defines a Risk Bearing Organization at section 1375.4 (g) as an entity that does all of the following: <ul style="list-style-type: none"> ■ Contracts directly with a health plan to provide services or arranges for health care services for the plan's enrollees ■ Receives compensation for those services by capitation or a fixed periodic payment ■ Pays claims to providers out of its capitated budget <ul style="list-style-type: none"> ■ "Claims" includes capitation under subsection (h) <p align="center">AMERICA'S PHYSICIAN GROUPS</p>	<p>No specific change requested. Thank you for your comment.</p>

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

<p>6-66</p>	<p>Bill Barcellona</p> <p>America's Physician Groups</p>	<div style="border: 1px solid black; padding: 10px;"> <div style="background-color: #1a3d54; color: white; padding: 5px; text-align: center;"> <h3 style="margin: 0;">WHAT IS AN "ORGANIZATION?"</h3> </div> <ul style="list-style-type: none"> ▪ The proposed rule includes a definitions section at pages 1-2 of the Text ▪ An "Organization" is defined on page 1 and must be an RBO as defined under the Statute at subsection (g) of the Statute ▪ It can directly contract with a plan, or ▪ It can subcontract with another Organization to arrange for the health care services of a plan's enrollees and meets the other requirements of 1375.4(g). <ul style="list-style-type: none"> ▪ Meaning it is paid on a capitated basis and pays claims ▪ In other words, it could be "sub-delegated" to another RBO <div style="text-align: right; margin-top: 10px;">  </div> </div>	<p>No specific change requested. Thank you for your comment.</p>
<p>6-67</p>	<p>Bill Barcellona</p> <p>America's Physician Groups</p>	<div style="border: 1px solid black; padding: 10px;"> <div style="background-color: #1a3d54; color: white; padding: 5px; text-align: center;"> <h3 style="margin: 0;">WHAT IS A "SUB-DELEGATING" ORGANIZATION?</h3> </div> <ul style="list-style-type: none"> ▪ The Department intends to require SB 260 filing compliance from all the entities that are capitated and accept administrative delegation for claims payment to providers: <div style="text-align: center; margin: 10px 0;">  </div> <p style="margin-top: 10px;"><i>(k) "Sub-delegating organization" means an organization that delegates any portion of the responsibility for providing or arranging for the health care services of a plan's enrollees to another organization on a capitated or fixed period payment basis.</i></p> <div style="text-align: right; margin-top: 10px;">  </div> </div>	<p>No specific change requested. Thank you for your comment.</p>

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

<p>6-68</p>	<p>Bill Barcellona</p> <p>America's Physician Groups</p>	 <p>EXAMPLES</p> <p>1. Plan capitates an IPA for all professional services and delegates the administrative claims payment function to the organization for any third party provider payments</p> <p><i>The IPA is required to report under SB 260 rules</i></p> <p>2. Plan capitates and delegates an IPA. IPA sub-capitates and delegates another IPA for 100% of its risk and assumed administrative function</p> <p><i>Both IPAs are required to report under SB 260 rules under this proposed rule</i></p> <p>3. Plan capitates and delegates an IPA. IPA sub-capitates a 6-doctor specialty practice</p> <p><i>The specialty practice is not required to report because it does not pay claims to any other providers on behalf of the IPA</i></p> <p style="text-align: right;">AMERICA'S PHYSICIAN GROUPS</p>	<p>No specific change requested. Thank you for your comment.</p>
<p>6-69</p>	<p>Bill Barcellona</p> <p>America's Physician Groups</p>	 <p style="text-align: center;">Risk Arrangement Disclosure to Sub-Delegating Organizations 1300.75.4.1</p> <p style="text-align: center;">  </p> <p style="text-align: right;">AMERICA'S PHYSICIAN GROUPS</p>	<p>No specific change requested. Thank you for your comment.</p>

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

		<div style="text-align: right; font-size: small;">15</div> <p style="text-align: center;">DISCLOSURE TO SUB-DELEGATED RBOS</p> <ul style="list-style-type: none"> ▪ Section 1300.75.4.1(a) ▪ If an RBO sub-delegates to another RBO, then it must comply with the same six disclosure requirements imposed on Plans under section 1300.75.4.1(a) <ul style="list-style-type: none"> ▪ Monthly eligibility list of assigned enrollees under contract with the sub-delegated RBO, within first 10 days ▪ Monthly Changes or terminations to the list of assigned enrollees, within first 10 days ▪ If enrollee eligibility information is processed in more than one report to the sub-delegated RBO, all reports shall be processed on the same date ▪ Annual contract date disclosure of the DOFR, utilization rates, all risk-adjustment factors ▪ Quarterly expense reconciliation ▪ 150-Day preliminary payment report ▪ The DOFR “matrix” should be changed from “physician” to “professional” ▪ Is the 10-day disclosure timeline practical? <div style="text-align: right; font-size: x-small;">  </div>	
6-70	<p>Bill Barcellona</p> <p>America’s Physician Groups</p>	<div style="text-align: right; font-size: small;">16</div> <p style="text-align: center;">DISCLOSURE TO SUB-DELEGATED RBOS</p> <ul style="list-style-type: none"> ▪ Section 1300.75.4.1(b) requires, effective 1/1/2019, Sub-delegating RBOs must annually disclose all payments to the sub-delegated RBO, including any fee schedules used, made during the immediate quarter and year-to-date. (YTD was added in this revision) ▪ Section 1300.75.4.1(c) requires an annual disclosure, commencing after 1/1/2019, on the contract date the PMPM for all capitated payments, including any deductions taken from the PMPM. <ul style="list-style-type: none"> ▪ While this works for PMPM capitation arrangements in commercial or Medi-Cal HMO, it may not work for percentage of premium capitation arrangements in Medicare Advantage. ▪ We welcome your input on any alternative solution for MA situations and will provide a comment to the Department on this point. <div style="text-align: right; font-size: x-small;">  </div>	<p>No specific change requested. Thank you for your comment.</p>

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

<p>6-71</p>	<p>Bill Barcellona</p> <p>America's Physician Groups</p>	<div style="background-color: #002060; color: white; padding: 20px; text-align: center;"> <h2 style="margin: 0;">Additional Standards Applicable to All Delegating Entities</h2> <h3 style="margin: 0;">1300.75.4.2</h3> </div> <div style="text-align: right; margin-top: 10px;"> <small>AMERICA'S PHYSICIAN GROUPS</small> </div> <div style="background-color: #002060; color: white; padding: 10px; text-align: center; margin-top: 20px;"> <h3 style="margin: 0;">NEW STANDARDS FOR ALL RBOS</h3> </div> <ul style="list-style-type: none"> ■ One year after the effective date of this regulation, a new cash-to-claims ratio of .75 under 1300.75.4(f), changed from .60. ■ Use the old ratio until the effective date occurs ■ All RBOs, regardless of whether they have 10,000 or less covered lives must comply with the quarterly financial survey reporting process ■ New information is added to the quarterly reporting form at 1300.75.4.2 (b)(1): <ul style="list-style-type: none"> ■ Existing: balance sheet, income statement, statement of cash flows ■ New: statement of net worth, cash and cash equivalent, receivables and payables, risk pool and other incentives, claims aging, notes to financial statements, enrollment information, mergers, acquisitions and discontinued operations, IBNR methodology and administrative expense ■ Must add year-to-date as well as the previous quarter <p style="margin-top: 20px;">See pages 4-5 of the Text</p> <div style="text-align: right; margin-top: 10px;"> <small>AMERICA'S PHYSICIAN GROUPS</small> </div>	<p>No specific change requested. Thank you for your comment.</p>
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DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

6-72	<p>Bill Barcellona</p> <p>America's Physician Groups</p>	 <ul style="list-style-type: none"> ▪ Sub-delegating RBOs must add a list of all contracting organizations, with all contact information, and list the enrollees assigned to the organization as of the last day of the preceding quarter ▪ Combining reports with an affiliate of the RBO, and the Department may require separate quarterly reporting from both entities ▪ Where the RBO uses a sponsoring organization relationship to reduce the RBO's liabilities for purposes of calculating TNE or working capital, the regulation adds the reduction of liability for the "cash-to-claims ratio" as the third potential reason for the relationship ▪ The positive TNE statement is changed to exclude unsecured affiliate receivables, except those arising in the normal course of business, payable on the same terms as equivalent transactions with non-affiliates <p>See pages 5-6 of the Text</p> 	<p>No specific change requested. Thank you for your comment.</p>
6-73	<p>Bill Barcellona</p> <p>America's Physician Groups</p>	 <ul style="list-style-type: none"> ▪ A change in the reporting trigger for deficiencies arising in the previous quarter to include cash-to-claims ratio, as well as the former requirement to report deficiencies in positive TNE and/or working capital ▪ Sponsoring Organization Arrangements: <ul style="list-style-type: none"> ▪ (a) An RBO may only rely on a sponsoring organization for no more than 1 year to reduce its liabilities or increase its cash for purposes of calculating its TNE, working capital or cash-to-claims ratio. But RBOs can apply for an extension. ▪ (b) A new process for application to use a sponsoring organization shall include projections showing how the RBO will attain compliance once the guarantee from the sponsoring organization terminates ▪ (c) If the period exceeds one year, RBOs are required to report annually projections on how it will achieve compliance <p>See page 6 of the Text</p> 	<p>No specific change requested. Thank you for your comment.</p>

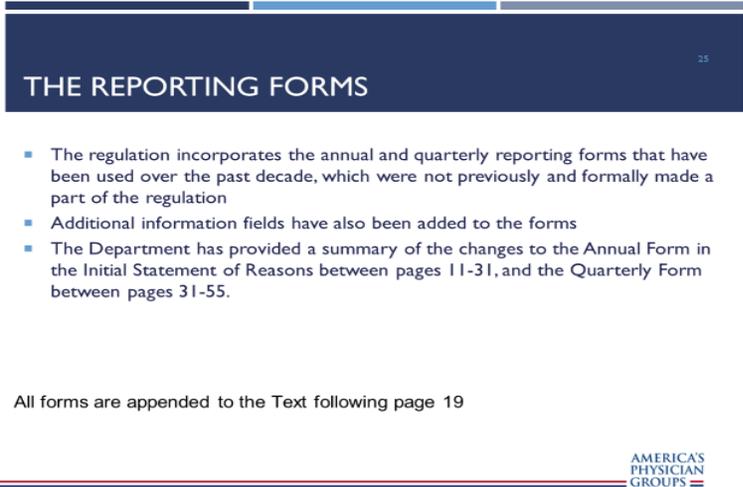
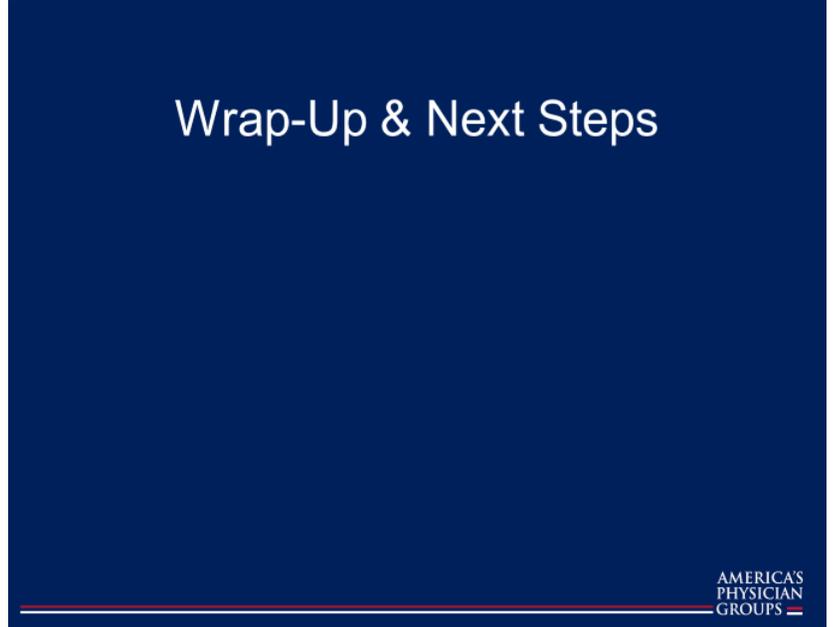
DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

<p>6-74</p>	<p>Bill Barcellona</p> <p>America's Physician Groups</p>	 <ul style="list-style-type: none"> ■ The annual reporting form incorporates the same granular detail changes as the quarterly form, plus: <ul style="list-style-type: none"> ■ (A) the sub-delegating organization shall disclose <ul style="list-style-type: none"> ■ Its allocation of risk to the sub-delegated organization ■ Whether it is providing stop-loss to the sub-delegated organization, with detail ■ All forms will require the principal officer of the affiliate to provide a verification, if a combined report is used ■ Any material deficiencies in the grading criteria shall be reported within 5 business days to the Department, the plan, and the sub-delegating organization, by the sub-delegated RBO. Sub-delegating RBOs must report any notice within 5 business days to the Department <p>See pages 9-11 of the Text</p> 	<p>No specific change requested. Thank you for your comment.</p>
<p>6-75</p>	<p>Bill Barcellona</p> <p>America's Physician Groups</p>	 <ul style="list-style-type: none"> ■ Any transfer of lives from a sub-delegated RBO must be reported up to the Plan by the sub-delegating RBO, to allow the Plan sufficient time to determine whether a block-transfer filing is required ■ Sub-delegating RBOs are held to the same standard as a Plan to maintain adequate procedures in place to review all sub-delegated RBO financials ■ Sub-delegating RBOs are held to the same standard as a Plan to administer financial oversight, including corrective action plan compliance to sub-delegated RBOs, include 5 day notice to the Department of any deficiencies in the grading criteria. ■ Sub-delegating RBOs must flow-down any contractual requirements imposed upon it by the Plan to the sub-delegated RBO. Provider bill of rights provisions apply to the sub-delegated relationship as they would between the Plan and the RBO. <p>See page 11-13 of the Text</p> 	<p>No specific change requested. Thank you for your comment.</p>

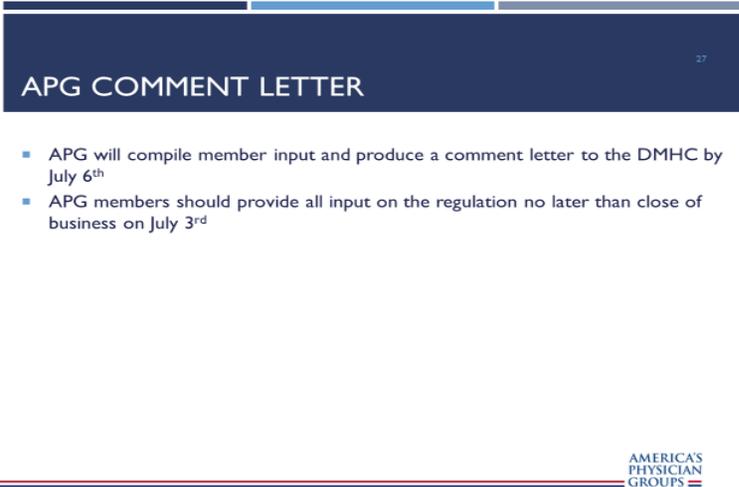
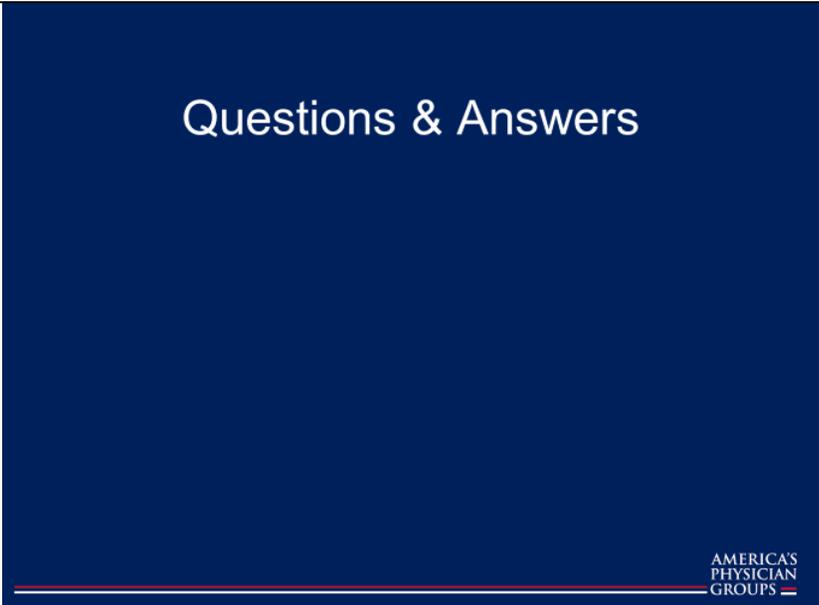
DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

<p>6-76</p>	<p>Bill Barcellona</p> <p>America's Physician Groups</p>	 <ul style="list-style-type: none"> ■ A form has been incorporated into the regulation, and the timelines for the process have been accelerated. ■ RBOs can self-initiate a CAP, or can apply to the Department to avoid a CAP if there are circumstances that demonstrate a one-time, minor hit to grading criteria compliance. ■ Upstream payers will have 7 calendar days, not 15, to object to a self-initiated CAP, or it will become final. ■ There are several other changes to deadlines in this section. <p>See pages 14-17 of the Text</p> 	<p>No specific change requested. Thank you for your comment.</p>
<p>6-77</p>	<p>Bill Barcellona</p> <p>America's Physician Groups</p>	 <ul style="list-style-type: none"> ■ Effective 1 year after the operative date of this regulation ■ "Positive tangible net equity" shall be equal to or the greater of: <ul style="list-style-type: none"> ■ 1% of annualized revenues, or ■ 4% of annualized non-capitated medical expenses ■ The tangible net equity shall not include the receivables of an affiliate, except those: <ul style="list-style-type: none"> ■ that are payable on the same terms as equivalent transactions with non-affiliates, and ■ that are not more than 60 days past due, with which the RBO has a risk arrangement ■ During the 1-year phase in, the RBO must comply with the previous year's TNE requirement <p>See pages 18-19 of the Text</p> 	<p>No specific change requested. Thank you for your comment.</p>

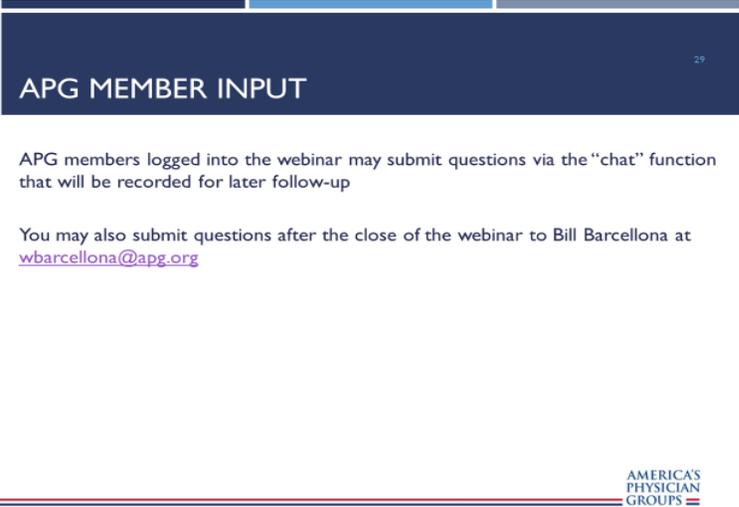
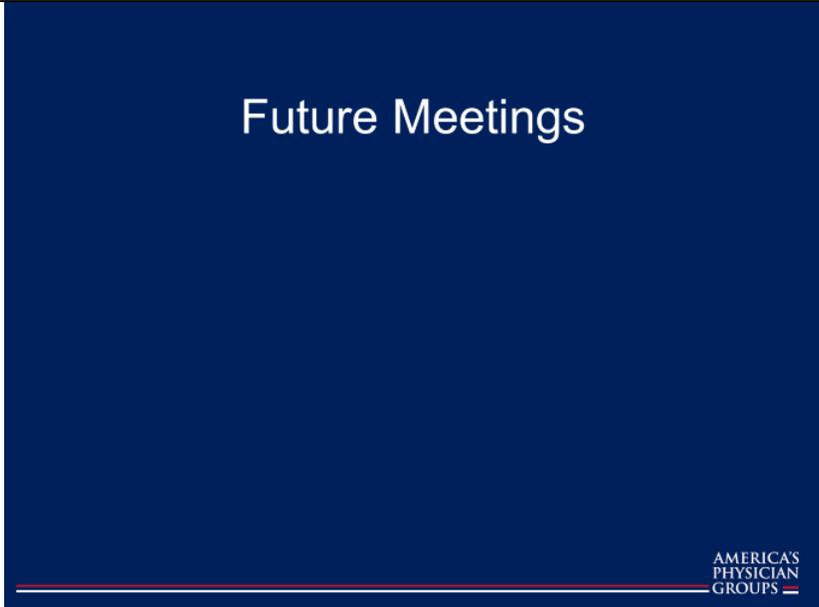
DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

<p>6-78</p>	<p>Bill Barcellona</p> <p>America's Physician Groups</p>	 <p>THE REPORTING FORMS</p> <ul style="list-style-type: none"> ■ The regulation incorporates the annual and quarterly reporting forms that have been used over the past decade, which were not previously and formally made a part of the regulation ■ Additional information fields have also been added to the forms ■ The Department has provided a summary of the changes to the Annual Form in the Initial Statement of Reasons between pages 11-31, and the Quarterly Form between pages 31-55. <p>All forms are appended to the Text following page 19</p> <p style="text-align: right;">AMERICA'S PHYSICIAN GROUPS</p>	<p>No specific change requested. Thank you for your comment.</p>
<p>6-79</p>	<p>Bill Barcellona</p> <p>America's Physician Groups</p>	 <p style="text-align: center;">Wrap-Up & Next Steps</p> <p style="text-align: right;">AMERICA'S PHYSICIAN GROUPS</p>	<p>No specific change requested. Thank you for your comment.</p>

**DEPARTMENT OF MANAGED HEALTH CARE
 Financial Solvency of Risk Bearing Organizations (2017-5216)
 Responses to Comments for
 Comment Period #1, May 25, 2018 – July 9, 2018**

		 <p>APG COMMENT LETTER</p> <ul style="list-style-type: none"> APG will compile member input and produce a comment letter to the DMHC by July 6th APG members should provide all input on the regulation no later than close of business on July 3rd <p align="right">AMERICA'S PHYSICIAN GROUPS</p>	
6-80	Bill Barcellona America's Physician Groups	 <p align="center">Questions & Answers</p> <p align="right">AMERICA'S PHYSICIAN GROUPS</p>	No specific change requested. Thank you for your comment.

**DEPARTMENT OF MANAGED HEALTH CARE
 Financial Solvency of Risk Bearing Organizations (2017-5216)
 Responses to Comments for
 Comment Period #1, May 25, 2018 – July 9, 2018**

		 <p>APG MEMBER INPUT</p> <p>APG members logged into the webinar may submit questions via the “chat” function that will be recorded for later follow-up</p> <p>You may also submit questions after the close of the webinar to Bill Barcellona at wbarcellona@apg.org</p> <p align="right">AMERICA'S PHYSICIAN GROUPS</p>	
6-81	Bill Barcellona America's Physician Groups	 <p align="center">Future Meetings</p> <p align="right">AMERICA'S PHYSICIAN GROUPS</p>	No specific change requested. Thank you for your comment.

**DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018**

California Policy Committee

All meetings will be held by phone and webex, using (800) 505-4464, pass code 806225# for the call-in

All meetings will be held between 2-3:00 pm.

Thursday, August 23
Thursday, November 29

APG Contracts Committee

Thursday, August 9
10:30 – 2:00 PDT
LA Office and WebEx

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October 8-10, 2018 • Hyatt Regency Washington on Capitol Hill • Washington, DC

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #1, May 25, 2018 – July 9, 2018

ⁱ www.cattaneostroud.com. Table 2A – List of Closed Medical Groups in Descending Yearly Quarters. Sourced on July 7, 2018 at: <http://cattaneostroud.com/wp-content/uploads/2017/05/2A-Web.pdf>. Page 55.

ⁱⁱ Excluding the Permanente Medical Group enrollment figures within Kaiser Foundation Health Plan.

ⁱⁱⁱ Excluding the Permanente Medical Group enrollment figures within Kaiser Foundation Health Plan.