

**DEPARTMENT OF MANAGED HEALTH CARE**  
**Financial Solvency of Risk Bearing Organizations (2017-5216)**  
**Responses to Comments for**  
**Comment Period #2, September 13, 2018 – September 28, 2018**

#	FROM	COMMENT	DEPARTMENT RESPONSE						
1-1	Talia Leon  Inland Empire Health Plan	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;">Page #</th> <th style="width: 40%;">Draft Regulation Language (Cut and paste excerpt language)</th> <th style="width: 50%;">Comment</th> </tr> </thead> <tbody> <tr> <td style="text-align: center; vertical-align: middle;">16</td> <td>(c) Unless, within <del>15</del> <b>7 calendar</b> days of the receipt of an organization's self-initiated CAP proposal, a contracting health plan <b>or sub-delegating organization</b> provides written notice to the Department and the <b>risk-bearing organization</b> state the reason for its objections and recommendations for revisions, the self-initiated CAP shall be considered a final CAP <b>subject to approval by the Department</b> subject to the Department's approval process as set forth in sections (g) and (h) below.</td> <td>The plan recommends 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 proposed CAP.</td> </tr> </tbody> </table>	Page #	Draft Regulation Language (Cut and paste excerpt language)	Comment	16	(c) Unless, within <del>15</del> <b>7 calendar</b> days of the receipt of an organization's self-initiated CAP proposal, a contracting health plan <b>or sub-delegating organization</b> provides written notice to the Department and the <b>risk-bearing organization</b> state the reason for its objections and recommendations for revisions, the self-initiated CAP shall be considered a final CAP <b>subject to approval by the Department</b> subject to the Department's approval process as set forth in sections (g) and (h) below.	The plan recommends 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 proposed CAP.	ACCEPTED. The DMHC has made the proposed amendment to the regulation.
Page #	Draft Regulation Language (Cut and paste excerpt language)	Comment							
16	(c) Unless, within <del>15</del> <b>7 calendar</b> days of the receipt of an organization's self-initiated CAP proposal, a contracting health plan <b>or sub-delegating organization</b> provides written notice to the Department and the <b>risk-bearing organization</b> state the reason for its objections and recommendations for revisions, the self-initiated CAP shall be considered a final CAP <b>subject to approval by the Department</b> subject to the Department's approval process as set forth in sections (g) and (h) below.	The plan recommends 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 proposed CAP.							
2-2	Stephanie L. Shirkey  California Association of Health Plans	<p>The California Association of Health Plans represents 47 public and private health care service plans (plans) that collectively provide coverage to over 28 million Californians. We previously submitted comments on the proposed rulemaking on the financial solvency of risk bearing organizations (RBOs) that the Department of Managed Health Care (Department) issued on May 25, 2018. Today, we write to provide comments on the revised rulemaking on that topic issued on September 13, 2018. We would like to thank the Department for incorporating several of the revisions we requested during the first comment period and for providing a second comment period. We take this opportunity to reiterate one of the comments we made during the first comment period.</p> <p>Under existing regulation, RBOs reporting deficiencies in any of the Grading Criteria, as defined, must submit a self-initiated Corrective</p>	ACCEPTED. Please see the response to comment #1-1.						

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		<p>Action Plan (CAP) proposal to the Department and to every plan with which the RBO maintains a contract involving a risk arrangement that meets certain requirements, except as specified. (28 Cal. Code Regs. § 1300.75.4.8(a).) The self-initiated CAP is considered a final CAP, subject to Department approval, unless a contracting health plan provides written notice to the RBO and the Department stating the reason for its objections and recommendations for revisions within 15 days of receipt of the self-initiated CAP proposal. (28 Cal. Code Regs. § 1300.75.4.8(c).) The proposed rulemaking significantly shortens that opportunity to review the CAP proposal and make recommendations for revisions. (Proposed 28 Cal. Code Regs. § 1300.75.4.8(c).) In order to ensure that impacted entities have sufficient time to review and respond to a CAP proposal, we recommend preservation of the existing 15-day review period.</p> <p>Thank you again for the opportunity to submit comments to these proposed regulations.</p>	
3-3	<p>William Barcellona, Esq. MHA</p> <p>America's Physician Groups</p>	<p>We noted no changes were made in the second version in response to our comments on the following sections of the first version to the following sections of the proposed Rule. We request that the Department provide clarification on the following issues in its Final Statement of Reasons and/or responses to stakeholder comment summary:</p> <p><b>O 1300.75.4:</b> The Definitions section of the proposed rule does not provide a definition of</p>	<p>This comment is irrelevant, as it pertains to existing language that is not being modified during this regulation period.</p>

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		“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.	
3-4	William Barcellona, Esq. MHA  America’s Physician Groups	<b>O 1300.75.4(f):</b> 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 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.	This comment is irrelevant, as it pertains to changes made during the first comment period.
3-5	William Barcellona, Esq. MHA  America’s Physician Groups	<b>O 1300.75.4.1(a)(4)(A):</b> 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.	This comment is irrelevant, as it pertains to existing language that is not being modified during this regulation period.
3-6	William Barcellona, Esq. MHA	<b>O 1300.75.4.2(a):</b> 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	This comment is irrelevant, as it pertains to changes made during the first comment period.

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	America's Physician Groups	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.	
3-7	William Barcellona, Esq. MHA  America's Physician Groups	<b>O 1300.75.4.2(b)(1)(B):</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.	This comment is irrelevant, as it pertains to changes made during the first comment period.
3-8	William Barcellona, Esq. MHA  America's Physician Groups	<b>O 1300.75.4.2(b):</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	This comment is irrelevant, as it pertains to changes made during the first comment period.

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		contracting cycle, or whichever is longer.”	
3-9	William Barcellona, Esq. MHA  America's Physician Groups	<b>1300.75.4.1(c):</b> Thank you for the change in version two to recognize the role of percentage of premium capitated payments to state: “ <u>or the respective amount under a percentage of premium arrangement.</u> ”	No specific change requested. Thank you for your comment.
3-10	William Barcellona, Esq. MHA  America's Physician Groups	<b>1300.75.4.1(a)(1-3):</b> Thank you for the partial change to the 10-day electronic transmission deadline to 15 days as set forth in subsections (1) and (2) to the second version of the proposed Rule. We had requested <u>sequential deadlines</u> be set forth, so the single expansion of the transmittal period from 10 to 15 days may still create confusion over the required deadline. For example, if a plan takes 15 days to transmit the information electronically to the RBO, the RBO will still have no time to transmit it to the sub-delegated organization.	DECLINED. As noted, the DMHC has extended the 10-calendar day electronic transmission deadline to 15 calendar days. The DMHC believes that the additional five calendar days provides adequate time to complete the transmission.
3-11	William Barcellona, Esq. MHA  America's Physician Groups	<b>Comments on the Attached Filing Forms:</b> We noted that the Department made significant changes to the fields associated with the filing forms, and that the Corrective Action Plan filing form appears to have been deleted in the second version of this proposed Rule. There was not enough time afforded by the Department in this comment period to gather comments from our association members on the changes to the filing forms, thus we cannot provide comments on those changes.  Please contact us should you wish to discuss our comments further.	No specific change requested. Thank you for your comment.  For the second comment period, the DMHC made changes to its Annual Financial Survey Report Form and Quarterly Financial Survey Report Form. Specifically, the DMHC made changes to the “Current Asset” section, “Tangible Net Equity” under Grading Criteria section, Schedule B, and Schedule I. The changes are shown as strikeouts and double underline. The DMHC did not make any changes to the Corrective Action Plan form.

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			Please note that the DMHC has attached the Annual Financial Survey Form, the Quarterly Financial Survey Form, and the Corrective Action Plan Form in subsequent comment periods.