

DEPARTMENT OF MANAGED HEALTH CARE
Financial Solvency of Risk Bearing Organizations (2017-5216)
Responses to Comments for
Comment Period #3, November 15, 2018 – December 4, 2018

#	FROM	COMMENT	DEPARTMENT RESPONSE
1-1	Bill Barcellona America's Physician Groups	<p>We noted no changes were made in the third version in response to our comments on the following sections of the first and second versions 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:</p> <p>○ 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.</p>	This comment is irrelevant, as it pertains to existing language that is not being modified during this comment period.
1-2	Bill Barcellona America's Physician Groups	<p>○ 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. Now that newly enacted statute will provide for the suspension of claims processing and other critical processing requirements under the Act in cases of the Governor’s declaration of a State of Emergency, we request the Department to clarify whether and how it will modify its oversight of RBOs involved in such situations when it comes to quarterly and annual reporting under this proposed Rule. Furthermore,</p>	This comment is irrelevant, as it pertains to changes made during a previous comment period.

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		<p>this proposed section does not clarify whether these are calendar or business days. The department has indicated the distinction elsewhere in the proposed text, for example at section 1300.75.4.1(a)(2), where it specifies “15 calendar days” at line three.</p>	
1-3	<p>Bill Barcellona America’s Physician Groups</p>	<p>O 1300.75.4.1(a)(4)(A): The matrix of responsibility for medical expenses includes existing language that states “<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. Since the Department did not accept our proposed change, we request clarification by staff that it understands the distinction.</p>	<p>This comment is irrelevant, as it pertains to existing language that is not being modified during this comment period.</p>
1-4	<p>Bill Barcellona America’s Physician Groups</p>	<p>O 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. There is also remaining uncertainty in this draft over the specific application of the new TNE standard. We request clarification that hat the 4% is not applied to any portion of expense that is capitated, i.e. PCP capitation, lab capitation, capitated specialty physician services and any other capitated service. Similarly, we request clarification that expenses for employed physicians, support team and facility expenses for clinics are not subject to the 4%</p>	<p>This comment is irrelevant, as it pertains to changes made during a previous comment period.</p>

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	<p>reserve, since those expenses are not claims expense. We suggest that that the Department would allow the use of a subordinated loan to obtain the initial TNE increase and as the group has yearly profits the subordinated loan could be paid back while still maintaining TNE compliance. Smaller IPAs need to maintain their existing levels of physician compensation, especially in the Medi-Cal managed care market, in order to maintain stability in their provider network. Any sudden decrease in expected compensation among contracted independent providers destabilizes IPA networks, and this works to the detriment of enrollee access in the short term. That is why some of our members have requested a slower phase-in period of 2-3 years for this specific provision. An example of how this new requirement will negatively impact smaller RBOs has been provided by one of our members:</p>	
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1-5	Bill Barcellona America's Physician Groups	<p>O 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.</p>	This comment is irrelevant, as it pertains to changes made during a previous comment period.																														
1-6	Bill Barcellona America's Physician	<p>O 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</p>	This comment is irrelevant, as it pertains to changes made during a previous comment period.																														

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	Groups	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 previously suggested during the last comment cycle that the proposed language be modified beyond 1 year to accommodate the “initial payer contracting cycle, or whichever is longer.” Since that was not changed, we request clarification in the final statement of reasons on the Department’s process to seek exemptions for longer periods of time.	
1-7	Bill Barcellona America’s Physician Groups	O 1300.75.4.1(c) : Thank you for the change in version two to recognize the role of percentage of premium capitated payments to state: “or the respective amount under a percentage of premium arrangement.”	No specific change requested. Thank you for your comment.
1-8	Bill Barcellona America’s Physician Groups	O 1300.75.4.1(a) (1-3) : 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	This comment is irrelevant, as it pertains to changes made during a previous comment period.

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		have no time to transmit it to the sub-delegated organization. Thank you for the opportunity to provide comment.	
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