Arnold Schwarzenegger, Governor
State of California
Business, Transportation and Housing Agency

980 Ninth Street, Suite 500
Sacramento, CA 95814
916-322-2078 voice
916-322-2579 fax

DATE: February 8, 2005

TO: INTERESTED PARTIES

FROM: Department of Managed Health Care

The following is a brief summary of the comments and events that occurred during the Financial Solvency Standards Board (FSSB) meeting held on December 14, 2004.

I. Opening Remarks and Adoption of Meeting Minutes

A. The Director described the formation of a financial crisis team to identify early warning symptoms for financially troubled medical groups so that the Department could better protect consumers, oversee the group's corrective action and, when necessary, more efficiently orchestrate the transition of enrollees to alternate providers.

B. The Deputy Director of Plan-Provider Relations explained potential disruptions in the delivery health care services that can result when a medical group encounters financial difficulties. In one medical group closure, doctors and nurses worked 45 days without a clear understanding as to who owned the practice or who was paying the bills. Staff lacked the ability to: retrieve patient information, contact patients, process authorization for release of medical records or do any other significant business. When the group closed, the landlord was left with custody of the group's medical records. Despite the landlord's cooperation and the Department and the group's contracting plans attempts to implement a procedure for patients to retrieve their medical records, many enrollees had difficulty obtaining their medical records.

California's health care delivery system has recently experienced a number of hospital closures. In addition to preservation of medical records, hospital closures also raise serious access concerns, especially if the hospital is a trauma facility and there is no other trauma facility in the area.

II. Revised Regulations Implementing SB 260

A. The Department staff overviewed the revisions made to the draft SB 260 regulations, including:

- A "cash to claims ratio" of 1.0 that allowed the inclusion of fee-for-service revenues that are reasonably expected to be collected within 30 to 60 days.
- RBO financial data submission 2005 business activity was expected with the first annual report due in 2006.

- Financial reporting on a combining basis among affiliated medical groups would be permitted to the extent that the groups could demonstrate that combining entities are legally and financially responsible to pay timely payment of each other's claims.
- The timelines for instituting Corrective Action Plans was shortened.

B. Board Comment

- The Department's desire to exclude all but immediate anticipated receivables is appropriate when considering the standards for a cash ratio.
- Cash ratio should be disclosed since current ratio and the TNE ratio are disclosed.
- Concern was expressed as to whether the addition of a cash ratio could be potentially challenged since SB 260 specifically identified four criteria. The department and the chairperson provided a historical perspective explaining that the four (4) criteria was never intended to be exclusive, but rather reflects what the drafters could think of at the time. The four (4) criteria are "at a minimum" clearly permitting the inclusion of additional criteria.
- If the cash standard includes fee-for-service revenue it should be limited to receivables falling within a 30-60 day timeframe to ensure that the receivable is available to pay claims.
- It was suggested that further consideration be given to whether the publication of a medical group's compensation matrix could adversely affect the integrity of the contract negotiation process between the one group and its contracting health plans.
- The threshold for confidential treatment of SB 260 disclosures requires that actual harm to the RBO's contract negotiations is likely.
- The Department maintains a two-pronged approach to the confidentiality issue: 1) where medical groups can demonstrate a substantial likelihood of actual harm stemming from the disclosure of specific data elements that information will be excluded from public disclosure and 2) the remaining financial data will be available to the public in a format that will not impede the group's ability to contract.
- The Department's administrative regulations also provide a process for medical groups to request confidential treatment for specific financial information in a required filing if the group can demonstrate actual harm.
- The Board requested greater specificity with regard to record retention, confidentiality for the development of corrective action plans and the scope of work anticipated to be accomplished by the external party.

C. Public Comments

<u>Medical Group Prospective</u>

- CAPG recommends against the inclusion of a cash-to-claims ratio because it was not specifically enumerated in the original legislation. As an alternative, the medical groups recommend establishing a work group to study the issue in depth.
- If an external party is used, it should abide by the same policies and procedures as the Department.
- The groups would benefit from greater specificity in the confidentiality section especially relating to the Statement of Organization and will identify the items in the Statement of Organization that are likely to jeopardize contract negotiations.

- CAPG has concerns that the regulations would authorize the Department to instruct plans not to contract with a particular medical group and that the revised definition of risk sharing arrangement will reduce the current level of plan disclosures.
- CAPG requested more flexibility in the permissible timeframes for correcting financial deficiencies.
- CMA expressed a concern that there is not clear authority for instituting a cash-to-claims ratio, but, if adopted, should include accounts receivable due within 60 days and be phased-in over time. The most important measure is the timely payment of claims.
- CMA also recommended that the confidentiality section be tightened and remained concerned that the disclosure of TNE, working capital and information in the Statement of Organization could impede contract negotiations. Use of "met/not met" designations is okay.
- CMA also agreed that the Department should exercise flexibility regarding CAP timelines.

Hospital System Perspective

- The hospital representative questioned the goal of disclosure and cautioned that if confidential material is sent to another agency, then the confidentiality of that material should be maintained by the receiving agency.
- Cash-to-Claims Ratio. This could be monitored without setting a specific standard. Concern was expressed as to what was included in the calculation of the cash ratio. Suggests that the Department monitor cash ratios of medical groups to establish what is reasonable, prior to setting a cash ratio standard.

Health Plan Perspective

- CAHP requested a better description of how the external party will be used.
- The definition of risk sharing arrangement is confusing and it's highly similar to risk shifting arrangement.
- Since the cash-to-claims ratio is not a standard GAAP accounting principal, it may be better to stick with the four criteria outlined in SB 260. Once implemented, if the Department determines that the four criteria are insufficient, then the cash-to-claims ratio should be considered.
- Failure to meet the AB 1455 standards should not trigger a CAP.
- Because these regulations will require contract amendments, a statement should be added to the regulation that could be incorporated by reference to minimize the paperwork needed to amend the contracts.

III. Next Steps/Closing Remarks

Following the closing remarks, the meeting was adjourned. The next meeting is scheduled for January 11, 2005 at the Burbank Hilton. Note: Subsequently, the January 2005 meeting was rescheduled to February 8, 2005.