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	SB 260	Draft Regulations	Plan Comment	Medical Group/Provider Comment	Consumer/Consultant/ Other Public Comment	FSSB Recommendations
Definitions/Org Criteria	**DEFINITIONS** A **"risk-bearing organization**" means a professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership a medical foundation exempt from licensure pursuant to subdivision (l) of Section 1206, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services, but does not include an individual or a health care service plan, and that does all of the following: (A) Contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees. (B) Receives compensation for those services on any capitated or fixed periodic payment basis. (C) Is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of a health care service plan that are covered under the capitation or fixed periodic payment made by the plan to the risk-bearing organization. Nothing in this subparagraph in any way limits, alters, or abrogates any responsibility of a health care service plan under existing law. Sec 1375.4 (g)(1).	"**Organization**" means a risk-bearing organization as defined in subdivision (g) of Section 1375.4 of the Code.	Clarify "organization" and "lawfully organized group of physicians" definitions. Clearly exclude non-IPA small physician practices, and specifically extend to a subcontracted IPA. (LHPC)	The definition of "organization" should include the exceptions set forth in the statute. (Kaiser)	Regulations relating to risk organizations erroneously assume that risk bearing and administration is always delegated together. The regs. should distinguish between oversight related to the delegation of care coordination, financial risk and administration. (2CCS) The definition should be revised to specify what type of risk may considered to potentially reduce or limit healthcare services to enrollees. (2CCS)	
		"Risk-sharing arrangement" means any compensation arrangement between an organization and a plan that may directly or indirectly have an effect of reducing or limiting health care services to enrollees. Rule 1300.75.4(a)(5)	Definition inconsistent with SB260 and too broad to achieve goals. (CAHP/HMOT/PC) Suggest including preventive care incentive payments, and fee-for-service payments, withhold payments, and stating full financial risk is assumed; otherwise claims cannot be paid for specific services on a capitated of fixed periodic payment basis. (CAHP/HMOT)	Definition is wordy, too negative and inaccurate. Alternative language: "a contractual arrangement for health care service in which payment is provided on a fixed, periodic or capitated basis and financial risk is assumed for all or part of the services rendered." (AMGA)	The proposed regulations fail to provide guidelines on how risk is to be calculated. (HARP) A broader definition of risk-sharing arrangements should be adopted, since risk is the heart of insurance regulation. (HA/VPA)	

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			Clarify if definition includes capitated contractual arrangements without risk pools or withholds. (SFHP) Encompassing withhold payments was not intended by legislation. Should not conflict with definition of risk-bearing organizations. (PC)		Delete last clause of definition, (health care services to enrollees). (Katz)	
	A "**provider organization** means a medical group, independent practice association, or other entity that delivers, furnishes, or otherwise arranges for or provides health care services, but does not include an individual or a plan. Sec.1375.4(f)	**"Lawfully organized groups of physicians"** means a medical group, independent practice association, or other entity that delivers, furnishes, or otherwise arranges or provides health care services, including a licensed health facility, but excluding an individual or plan. Rule 1300.75.4 (4)(5)(b)	1375.4 (g) does not give the Director authority to impose these provisions on licensed health care facilities. (CAHP/HMOT) Clarify if non-IPA small physician practices will be excluded as suggested by LHPC. (LHPC)	Provision is unclear, extremely broad, and unnecessary. (AMGA/CMA) Reference to a "licensed health care facility " should be deleted since it cannot be a lawfully organized group of physicians. (CMA) Insert "controlled by physicians" after "or other entity;" insert " in compliance with Business & Professions Code Sec. 2400 after "health care services;" delete "including a licensed health facility. (CMA) A distinction between IPAs (which pays physicians on a FFS basis) and staff model groups (which employ physician on a salaried basis) should be considered due the delays incurred when receiving claims. (Hill)	Insert "Under California or federal law" after "entity that" and before "delivers". (Katz)	
	A "**sponsoring organization**" is one that has tangible net equity of a level established by the director that is in excess of all amounts that it has guaranteed to any person or entity. Sec. 1375.4 (b)(1)(B)					

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		"**Corrective action plan**" means a document with terms and conditions for correcting, and monitoring an organization's efforts to correct: (A) Any repeated failure to reimburse, contest, or deny claims, or estimate or document incurred but unreported claims, in accordance with Rule 1300.75.4.2, with a frequency which evidences a business practice or course of conduct; (B) Any failure to maintain, at all times, minimum tangible net equity or minimum working capital, in accordance with Rule 1300.75.4.2. Rule 1300.75.4 (a)(1)(A)-(B).	Delete conditions triggering an action plan from definition. Explain ambiguous timing requirements. Clarify method to grade organizations, i.e. financial information, and grade triggering action, rules triggering a plan, i.e., net equity, or working capital, and related standards, "failure" and "repeated failure" (suggest using HCFA 95% test as standards). (CAHP/HMOT)	Definition fails to provide that the corrective actions are to be "mutually agreed upon". Regs suggest that the external party will draft plan. (CMA) (B) Strike "at all times" as it is unrealistic and burdensome. (AMGA)		
		"External party" means an independent review entity that administer a process for reviewing or grading organizations and a process for corrective action plans, pursuant to a contract with the Department which provides for an objective evaluation, preserves the confidentiality of proprietary information, and prevents conflicts of interest with the plan or organization. Rule 1300.72.4(a)(2).		Definition is ambiguous; requires further clarification. (AMGA) Explain how the external party is selected and paid. If there will be more than one external party how will consistency be maintained? (Brown) While the external party should not have any conflicts of interest with either the plan or organization, it is unrealistic to assume that the external party will eliminate conflicts between the plan and the organization. (CMA) Insert "an objective" after "administer" and before "process (CMA)	These proposed regulations fail to adopt minimum qualification standards for, outline the selection process of, or describe the Department's oversight of the external party. (HARP) This definition should disclose what types of entities qualify as an external party. (Phoenix)	

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				Delete “prevents” and insert “has no“ before the word “conflicts.” (CMA)		

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		"**Proprietary information"** means information that must be kept confidential to avoid an adverse affect on the integrity of the contract negotiation process between a plan and an organization, as determined by the external party. Rule 1300.75.4(a)(4).	Clarify definition and/or allow external party to develop guidelines for definition, as organizations may argue all information required to be disclosed to the external party meets the existing proprietary definition. (PC)	Organizations should have the ability to designate information as confidential or proprietary; broaden the definition to include confidential information not affecting the integrity of the negotiation process. (Brown/CMA) Delete "must" and insert "should;" add "the potential" after the word "avoid." (CMA)	Insert "Written policy of" after "by " and before "the external party" (Katz)	
	A "**qualified guarantee"** is one that meets all of the following: (i) approved by a board resolution of the sponsoring organization; (ii) the sponsoring organization agrees to submit audited annual financial statements to the plan within 120 days of the end of sponsoring organizations fiscal year; (iii) the guarantee is unconditional, except for a maximum monetary limit; (iv) the guarantee is not limited in duration with respect to liabilities arising in the term of the guarantee The guarantee provides for 6-months advance notice to the plan prior to its cancellation. Sec 1375.4(b) (1)(B)(i)- (v).					
	"Claims" include, but are not limited to, contractual obligations to pay capitation or payments on a hospital payment basis. Sec. 1375.4 (h).					

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	ORGANIZATIONAL CRITERIA The Director shall adopt regulation minimally providing for a process of reviewing or grading risk bearing organizations along the following criteria: Whether it reimburses, contests, or denies claims for health care services it has provided, arranged, or for which it is otherwise financially responsible in accordance with the time frames set out in Section 1371. Whether it estimates its liability for incurred but not reported claims pursuant to a method not objectionable to the director . Whether it maintains at all times a tangible positive net equity as defined in Reg. 1300.76 (e). Whether it maintains at all times a positive level of working capital (excess of current assets over current liabilities. Sec. 1375.4 (b) (1)(A) (I)-(iii). A risk bearing organization may reduce its liabilities for the purposes of calculating tangible net equities by the amount of any liabilities the payment of which is guaranteed by a sponsoring organization pursuant to a qualified guarantee. Sec. 1375.4(b)(1)(B).	(a) Every contract between a plan and a organization shall require the organization to do all of the following: (1) Reimburse, contest, or deny every claim for health services it has provided, arranged for, or for which it is otherwise financially responsible for in accordance with the time frames and other requirements described in sections 1371 and 1371.25 of the Code, and in accordance with any other applicable state and federal laws and regulations;	(1) The contract should be limited to those claims for which the organization is responsible pursuant to the contract with the particular plan. (CAHP/HMOT) Limit the "incurred but not reported" provision to apply only when an organization incurs liability through a fee for service arrangement for the provision of medical care. (SFHP) Change "incurred but not reported" provisions to apply only when organization incurs liability through fee-for-service arrangement with its providers. (LHPC)	(a)(1) Delete "every" & change claim to claims. (AMGA) A 2-5% tolerance factor should be included in the requirement for the payment of claims. (Hill) This section needs to distinguish between delegation of financial risk and delegation of responsibility for the administration of plan benefits and payment of providers. (2CCS) The methodology of monitoring compliance should be consistent with HCFA and HMCOT. (2CCS) If a provider uses capitation to pay subcontracted providers, a report of the timeliness of capitation should be included. (2CCS)		

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		(2) Estimate its liability for incurred but unreported claims on a monthly basis pursuant to a "lag study" method as defined and illustrated in Rule 1300.77.2(c) or an "actuarial estimate" method as defined and specified in Rule 1300.77.2(d), and document this estimate at least quarterly as an accrual in its books and records, and document this accruals in all its financial statements. (3) Maintain at all times a positive tangible net, as defined in Rule 1300.76(e), of at least fifty thousand dollars ($50, 000)	(2) Change "document this estimate at least quarterly … and document this accrual in all of its financial statements" to "… and accrue this estimate at least quarterly on its books and records, including its financial statements." (CAHP/HMOT)	(a)(2) Change "incurred but not paid" to "incurred but not reported." (AMGA) Add "or a combination or other methodology approved by the department" after "lag study method." (AMGA) (a)(3) Delete reference to dollar amount and "at all times." (AMGA/CMA) $1 is "positive" - there is no authority for setting arbitrary levels of working capital. (Brown) Phase in the financial solvency requirements for organizations. (Brown) (a)(3) & (4) Recognition for seasonal fluctuations in physician services should be included since the demand for services is much higher in the first half of the year. (Hill) Change "maintain at all times" to "maintain on a monthly basis" to be consistent with the preparation of financial statements. (Hill)	(a)(2) Consider including other indicator of fiscal distress: delays in scheduling appointments, delays in referrals to specialists, decreases in the number of referrals to specialists, restrictive criteria for second opinions, decreases in pharmaceutical treatments and changes in physician practices. (HA) (a)(3) & (4) Depending on the size of the organization, TNE of $50,000 and working capital of $25, 000 is too low. (HARP)	

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		(4) Maintain at all times a positive level of working capital comprised of liquid assets of a least twenty-five thousand dollars ($25,000) in excess of current liabilities. "Liquid assets" means cash or securities specified as cash "equivalents" in Rule 1300.77(b) deposited with any bank authorized to do business in this state and insured by the FDIC. (b) An organization may reduce its liabilities for purposes of calculating its tangible net equity and working capital in a manner allowed by Section 1375.4(b)(1)(B) of the Code. For purposes of Section 1375.4(b)(1)(B) of the code , a sponsoring organization shall have a tangible net equity of a t least $10,000,000. Rule 1300.75.4.2(a)(1)-(4).	(4) $50,000 net equity and $25,000 working capital requirements may be too low or too high for some organizations. (CAHP/HMOT/PC/CAP) $50,000 TNE and $25,000 liquid assets requirements are inappropriate for some organizations, based on its size, and membership size. Suggests setting requirements in correlation to level of services organization and total membership for all risk-sharing arrangements. (SFHP) Suggest TNE and asset required levels set according to level of covered services, membership and risk assumed by organization in aggregate for all of its risk sharing arrangements. (LHPC) Establishing TNE and working capital levels greater than merely positive appears to be beyond scope of Department's authority in the statue. (CAHP/HMOT)	(a)(4) Needs significant revision; def. of "liquid assets" unnecessary; requirement should be limited to "maintaining a positive level of working capital." (AMGA) Delete def. of "liquid assets" and insert a definition for "working capital." Working capital is the excess of current assets over current liabilities. In addition to maintaining positive working capital, current assets should include at least $25,000 of cash or securities specified as cash 'equivalents.' (Brown) Use a standard definition of working capital recognizing ALL current assets (accounts receivable and marketable securities.) (Hill) (b) Recommend that this provision be phased out over a 3-5 year period since there is a flaw in the design of this provision that may allow the sponsoring organization to effectively avoid responsibility. (Hill)		

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			General Comments: Allow plans to terminate or modify contract so that certain services or functions are not delegated when an organization fails to meet criteria and has not satisfactorily undertaken a corrective action plan. (CAHP/HMOT) Third party coverage is not readily available to most plans. (SFHP) Change disclosure of capitation information to annual basis for the organization as it does not change more often than annually. (SFHP)	*General Comments:* Conduct a preliminary study to determine the type/amount of information available to providers before promulgating financial standards. (AMGA) Small IPAs may find reserves and audit standards difficult to meet. (Alksne) Consider adopting standards reporting forms, audit processes and patient educ. Materials. (Alksne) Working capital should include both marketable securities and accounts receivables. (Hill)	*General Comments:* Consider the necessity of a transition period for providers that are initially non-complaint. (2CCS) Consider allowing providers to use irrevocable subordinate lines of credit from health plans as a financing vehicle during the initial transition period. (2CCS) The draft Regs. are attempting to treat medical groups as if they were large insurance companies. As written 90% of existing groups would be permanently out of compliance. (Phoenix)	
Risk Sharing/Org Info	**RISK SHARING DISCLOSURE** For every contract between a risk bearing organization and a plan: 1. The risk bearing organization must furnish financial information to the plan and meet other financial requirements that assist the plan in maintaining the financial viability of its arrangements for the provision of health care services 2. The plan must disclose information to the risk-bearing organization that enables the risk bearing –bearing organization to be informed regarding the financial risk assumed under the contract, including; (A) Enrollee information monthly. (B) Risk arrangement information, information pertaining to any pharmacy risk assumed under the contract,	(a) Every contract between a plan and an organization shall require the plan to do all of the following: (1) Disclose in writing, on a monthly basis, the following information for each enrollee assigned to the organization: name, age, gender, zip code of residence, plan contract selected, any other third party coverage, and the primary care	(a) Amend to state: Every contract between a plan and an organization that contains a payment arrangement in which full financial risk is assumed for services on a capitated or fixed periodic payment basis shall require. (CAHP/HMOT) Clarify incorporation by reference is acceptable. (LHPC) (1) Disclosure should not be required to be submitted every month for unchanged enrollee information. (CAHP/HMOT)	(a) Limit “every contract” to capitated or risk contracts. (Brown/CMA) (a)(1) Add the following data information: date of birth; plan assigned #, plan assigned employer #, SS#, effective dates, complete address, COB info, selection and effective date of PCP.	**(**a)(1) Capitation payments should be calculated in the plan’s monthly patient report by assigning each member to a predefined “expense class,” the plan should then calculate the anticipated amount required to provide the risk bearing organization with a probability of less than 5% that the organization’s liquid assets will not fall below $25,000(HARP) Include date of birth and the effective dates for	

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	information regarding incentive payments, and information on income and expenses assigned to the risk-bearing organization quarterly. 3. Plans are required to provide payments of all risk arrangements, excluding capitation, within 180 days after the close of the fiscal year. Sec.1374.5(a)(1)-(3)	physician. (2) Disclose in writing to the organization, on a monthly basis, the names and total numbers of enrollees added or terminated under each plan contract served by the organization; (3) Disclose, as part of the contract with the organization, the following information for each and every risk-sharing arrangement under the contract: the nature of the risk-sharing arrangement; the purpose of the risk-sharing arrangement; the method for determining each and every amount (including expenses and income) allocated to the	(2) Should include retroactive additions or deletions, and other corrections. (CAHP/HMOT) (3) Semi-annual rather than quarterly reporting is desirable, as expenses fluctuate during a year, claims lag, and it may encourage accrual of risk-taking prematurely. (CAHP/HMOT)	(Brown/CMA) Add the fixed periodic prepaid payment amount, sex, coordination of benefits or third party liability information member category for governmental programs and other information to determine the actuarial soundness of prepayment. (CMA) The member's address should also be included. (Hill.) (a)(1) & (2) Amend "disclosure in writing " to include electronic submission of data. (Hill) (a)(2) include specific eligibility or termination date for EES. (Brown/CMA) Disclose whether a new member is a new enrollee for the plan or merely changing PCPs- in which case the plan should identify the previous PCP. (Hill)	termination and additions. (2CCS) (a)(1) & (2) amend "disclosure in writing" to allow for digital, electronic or magnetic forms and formats of data transmission. (2CCS/Katz)	

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		organization and to the plan under the risk-sharing arrangement; a separate explanation of the method of calculating each and every amount allocated to the organization and to the plan for the provision of any pharmacy services under the risk-sharing arrangement; and the time period for the risk-sharing arrangement. (4) Disclose in writing to the organization, on a quarterly basis, a detailed description of each and every amount (including expenses and income) allocated to the organization and to the plan under each and every risk-sharing arrangement. (5) Provide payments of all risk-sharing arrangements, excluding capitation, no later than 180 days after the close of the organization's fiscal year. Rule 1300.72.4.1 (a)(1)(5)	(4) Change "fiscal year" to or add "contract year." Permit plan-organization contracts to specify end of fiscal or contract year. Clarify if payments after 180 days are allowed to rectify payment errors due to incomplete or inaccurate data. (CAHP/HMOT) Quarterly submission is not useful as expenses may fluctuate and claims lag, and encourages premature risk-sharing for organizations. Suggest quarterly submission of more general information, and semi-annual submission of particular information. (PC) (5) Suggest end of contract year be defined by contract between plan and organization. (LHPC)	(a)(4) Insert a timeframe for plan disclosures – 30-days. Clarify that disclosure is required "for each and every risks pool." (Brown) Require plans to complete these disclosures within 30 days of the end of the quarter so that providers can complete their reporting requirements within the required 45 days. (Hill) The specific level of detail required for plan disclosures should be set forth in the reg. including a requirement that plans disclose the detail of claims paid out of each risk fund. (Hill) (a)(5) Include an appeals process to resolve payment disputes; if plan contract is terminated mid-year, plan shall provide all payments within 180 days after the termination date. (Brown)	(a)(5) This regulation must provide an enforcement mechanism for the 180 requirement that is standard in most plan/provider contracts but routinely ignored by the plans. Consider requiring quarterly risk pool payments. (Phoenix) The administration of risk	

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					sharing agreements is not necessarily tied to the fiscal year of the organization. As such payments should be made no less than annually and no less than 180 days after the close of the calendar year or other period specified in the plan/provider contract. (2CCS)	

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		(b) In addition to the disclosures required by subsection (a) of this rule, every contract between a plan and an organization shall require the plan to disclose, as part of the contract, the amount of payment for each and every service to be provided under the contract, including any fee schedules or other factors or units used in determining the fees for each and every service and, in the case of capitated payment, the amount to be paid per enrollee per month. Rule 1300.72.4.1(b)	(b) No need to list fee schedule in contract. Requiring "each and every amount" is too detailed, not appropriate. Include methodology to allocate financial responsibility, and a fee schedule for fee-for-service contracts. Do not include an expense by expense itemizations, or actuarial assumptions or analyses that would compromise contract negotiation process integrity. (CAHP/HMOT/PC) Plans should be able to provide for incorporations of contract provisions required by statute through reference to regulations in provider contracts. (PC) Clarify "other factors" do not include actuarial assumptions or analyses or other business or competitive considerations. (LHPC) *General Comments:* Impossible for plans that operate incentive pools based on overall annual plan performance. (CAHP/HMOT) Many plans do not have third-party coverage information on enrollees, do not require selection of primary care physicians, or do not collect this data, and do not provide zip code information in this data. (CAHP/HMOT)	(b) Add "service codes" (i.e. CPT codes), after the words "fee schedules." (Brown) *General Comments:* Require plans to disclose all affiliates in writing in the provider contracts. (Brown) Require that the eligibility and capitation reports coincide. (Brown) Prohibit plans from making unilateral deductions from capitation checks as deductions affect plan solvency. (Brown)	(b) Consider requirements that express the information relating to the various arrangements in terms of percentage of premiums or derivatives of premium. (2CCS) Disclosures should include the amount to be paid per enrollee per month for each and every class of enrollees. (Katz) *General Comments:* The regulations need to establish procedure to monitor plan compliance with disclosure requirements. (Phoenix.)	

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			Clarify the extent to which plans will be required to disclose to physicians, and extent to which plans will be required to oversee IPA's financial incentive program. (VHP)	Require plans to retroactively reimburse an organization's capitation to the date of the patient's enrollment. Brown Set forth the remedies and consequences in the event that a plan fails to meet its obligations. (Brown/CMA) Add a new subsection requiring the disclosure of "the name of each enrollee for whom the provider organization is taking risk for pharmacy along with the amount of funding for each enrollee, which should include information necessary for the provider organization to determine the financial risk assumed under the contract. (CMA) Require plan disclosure of its actuarial report demonstrating that capitation payments are actuarially sound. (CMA)		
	ORGANIZATIONAL INFORMATION The information required from risk-bearing organizations to assist in reviewing or grading these risk-bearing organizations, including balance sheets, claims reports, and designated annual, quarterly, or monthly financial statements prepared in accordance with generally accepted accounting principles, to be used in a manner, and to the extent necessary, provided to a single external party as approved by the director to the extent that it does not adversely affect the integrity of	Every contract between a plan and an organization shall require the organization to do all of the following: (a) Submit to the external party not	Use of an external party may be duplicative. Clarify terms for delegating financial review to a third party. Provide more guidance for third party to evaluate organization's ability to satisfy criteria, when to notify or provide additional information to the plan. (CAHP/HMOT)	(a) To avoid duplication	Consideration should be given to utilizing two separate entities to conduct the required audits: (1) CPAs for financial audits and (2) claims auditors for claims audits. (2CCS) (a)(1)-(4) This section fails	

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	the contract negotiation process between the plan and the risk-bearing organization. Sec. 1375.4(b)(2).	more than 45 days after the close of each quarter of the fiscal year, a quarterly status report containing: (1) Financial statements (including at least a balance sheet, an income statement, a statement of cash flows, and footnote disclosures), or comparable financial statements in the case of a nonprofit entity, for the immediately proceeding quarter prepared in accordance with GAAP; (2) A statement as to whether or not the organization has reimbursed, contested, or denied all claims received during the quarter, in accordance with Rule 1300.75.4.2. If any claim has not been reimbursed, contested or denied, as required by that rule, the statement shall be accompanied by a report that describes the following with respect to each deficient claim: claim number, date of receipt, contracting plan, name of the claimant, claim amount, the reasons why the claim is not meeting the requirements of applicable law, any action taken to	(2) Failure to pay claims for reasons other than financial problems are beyond the regulation's scope, and such reporting requirements would be burdensome and unnecessary. (CAHP/HMOT)	provide that the plan is prohibited from requiring any additional similar reporting from any of the organizations. (Brown) Delete "quarterly" insert "annually." (CMA) Differences between 4th quarter reports and the audit reports should be expected due the uncertainty of accounts receivable 45 days after the quarter. (Hill) Remove the quarterly obligation for footnote disclosure – limit them to annual reporting. (Brown) (a)(2) Change reporting requirement from individual claims to percentage of total claims which will significantly reduce the administrative burden. (Brown) Tolerance parameters of 2-5% should be established. (Hill) (a)(2)First sentence should be deleted as it goes beyond scope of Rule 1300.75.4.2. (AMGA)	to require sufficiently detailed reports to allow health plans and the Dept. to closely monitor changes in performance. or financial conditions of providers. It does not promote the use of standardized methodologies, an annual audit is not frequent enough, a full audit is prohibitively expensive, CPA firms may not be ideally suited to perform the audit. (2CCS) An alternative is develop a simple, uniform self-reporting mechanism, which would include activity levels, turn-around times and inventory for various categories of claims. (2CCS) DMHC should develop a uniform format for all required reports. (Phoenix.) Disclosure requirements should specify that the quarterly reports are due within 45 days of the close of each quarter based upon the organizations' fiscal year. (Katz)	

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		correct the deficiency, and any results of that action. (3) A statement as to whether or not the organization has estimated and documented its liability for incurred but unreported claims received during the quarter, in accordance with Rule 1300.75.4.2. If the estimated and documented liability has not met the requirements of the rule in any way, the statement shall be accompanied by a report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action. (4) A statement as to whether or not the organization has at all times during the quarter maintained a positive tangible net equity ("TNE") and positive level of working capital as required by Rule 1300.75.4.2. If the required TNE or working capital have not been maintained at all times, the statement shall be accompanied by a report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action. (5) A written verification attached to each report made under paragraphs (1), (2), (3) and (4) of this subsection stating that the report is true and correct to the best knowledge and belief of the principal officer of the organization, and signed by the		(a)(3) Change "during the quarter" to "as of the end of the quarter." (AMGA) Replace last sentence of paragraph with, "If this has not been completed, a statement explaining why this process has not been completed should be required." (AMGA) (a)(4) The second sentence should be deleted and substitute "If the required TNE or working capital have not been maintained, a simple statement indicting the reason it has not been maintained should be requires." (AMGA) Delete reporting requirements since they are also required under the "Corrective Action Plan" section. (Brown) Change "at all times" to "at the end of the month." (Hill) (a)(5)Delete "principal officer," substitute "designated officer." (AMGA) Change "principal officer" to "the attestation of the chief financial officer." (Hill)	(a)(4) Many medical groups cannot currently meet TNE and working capital requirements. A phase in period and consideration for smaller groups is needed. (Phoenix) If the group has not "at all times" maintained a "positive" TNE should it be placed on a "Watch List?" (Phoenix)	

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		principal officer. Rule 1300.75.4.3 (a)(1)-(5).	*General Comments:* Clarify plan responsibilities to perform additional financial oversight from current quarterly or annual audits conducted with IPAs. (VHP)			
		(b) Submit to the external party, not more than one hundred twenty (120) days after the close of the fiscal year, an audit report prepared by an independent certified public accountant in accordance with generally accepted auditing standards (or governmental auditing standards in the case of a public entity), containing all of the following:	(b) Clarify types of discrepancies investigated by external reviewer, plan responsibilities to provide evidence of contracting with external reviewers, and plan requirements to ensure IPAs use third party reviewer for claims processing and financial activities. (VHP) Suggest financial statement submitted be in standardized formats. i.e., plans' Orange Blanks. (LHPC)	(b) Timeline should be 180 days. (AMGA/Brown/Hill) Clarify that "audit reports" are intended to mean annual reports, not audited financial statements, which are very expensive. (CMA) The process of supplying financial information needs to be streamlined. (CMA)	(b) Clarify that audit reports are not Independent Certified Audits, which cost $30-50,000. Consider Complied or Reviewed financial statements or Certification by CFO or CEO. (Phoenix)	
		(1) Financial statements (including at least a balance sheet, an income statement, a statement of cash flows, and footnote disclosures), or comparable financial statements in the case of a nonprofit entity, for the immediately preceding fiscal year, prepared by the independent certified public accountant in accordance with generally accepted accounting principles ("GAAP"). For purposes of determining the independence of the certified public accountant, the regulations of the California State Board of Accountancy (Division 1, Sections 1 through 99.2, Title 16, California Code of Regulations), shall apply. (2) A verification of whether or not the		(b)(2) This language unduly		

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		information submitted to the external party by the organization pursuant to paragraph (2) of subsection (a) of this rule is accurate or inaccurate based on the accountant's review of a random sampling of claims selected by the accountant. (3) A verification of whether or not the information submitted to the external party by the organization pursuant to paragraph (3) of subsection (a) of this rule is accurate or inaccurate, based on the accountant's review of the information used by the organization to support its estimated liability, document its estimate as an accrual in books and records, and document this accrual in its financial statements. (4) A verification of whether or not the information submitted to the external party by the organization pursuant to paragraph (4) of subsection (a) of this rule is accurate or inaccurate, based on the accountant's review of the information used by the organization to prepare its quarterly financial statements. (5) A report of any inaccuracies noted by the accountant with respect to the reviews conducted under paragraphs (2), (3), and (4), of this subsection, containing, for each inaccuracy, a description of the inaccuracy, the		restricts the auditor 's judgment and may increase costs. (Brown) Currently, plans routinely audit the timing of our claims payment, this provision duplicates those efforts and expenses. If the provision is maintained, plans should be prohibited from conducting similar audits. (Hill) (b)(3) & (4) provisions are unnecessary. Absent a substantial deviation between quarterly reports and the year end audit, a corrective plan/ independent auditors is an unnecessary burden to place on providers. (Hill) If paragraphs (2), (3) & (4) are adopted, this section will further increase audit fees. (Hill)	(5) It is unlikely that any CPA firm will be willing to verify the accuracy of these items based on a sample. (Phoenix)	

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		reasons for the inaccuracy, any action taken to address the inaccuracy, and any results of that action. (6) An opinion of the accountant indicating that the financial statements present fairly, in all material respects, the financial position of the organization, and that the financial statements were prepared in accordance with GAAP. Rule 1300.75.4.3 (b)(1)-(6). (c) Provide written notice to the external party within thirty (30) days after the engagement of any new independent certified public accountant that will prepare the annual audit report and financial statements required by subsection (b) of this rule. The written notice shall state whether there was any disagreement with the former accountant on any matter in connection with the preparation of the most recent audit report or financial statements reported upon by the accountant. If there was any disagreement, the written notice shall describe the reasons for the disagreement. The written notice shall be signed by the principal officer of the organization. In addition, the organization shall request, in writing, the former accountant to furnish the organization with a written response stating whether the former accountant agrees with the statements contained in the organization's written notice. If the former accountant disagrees with any of the organization's statements, the former accountant's letter shall explain the reasons for disagreeing	(c) Many organizations do not have independent financial audits and will incur additional costs. (LHPC)	(c) Limit notification requirement to changes in auditors DURING an engagement. Otherwise, the ability to secure bids for this work may be restricted. (Brown) Delete subsection (c), as there is no statutory authority for this section, is unnecessary and burdensome. (CMA)	(c) Requesting this opinion letter does not make sense and a released firm is not likely to be objective. (Phoenix)	

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		with the organization's statements. The former accountant's letter shall be submitted with the written notice. Rule 1300.75.4.3 (C).				
		(d) Notify the external party no later than one (1) business day from discovering that the organization has allowed: (1) any repeated failure to reimburse, contest, or deny claims, or to estimate or document incurred but unreported claims, in accordance with Rule 1300.75.4.2, or (2) any failure to maintain, at all times, minimum TNE or minimum working capital, in accordance with Rule 1300.75.4.2. Rule 1300.75.4.3 (d).	(d) One day is an insufficient reporting time frame. Claims reporting should be done monthly. (CAHP/HMOT) Medical groups might not currently have certified financial audits and compliance would be costly and burdensome. (SFHP) Propose regulatory compliance exists when organization fails to notice FSSB pursuant to discovery either actual or constructive. (LHPC) Change 1 business day to 3 business days to ensure compliance. (SFHP)	(d) Increase notification period from I to 5 days. (Brown) Increase reporting period to allow for verification and to reevaluate its systems. (CMA/Hill) Define “repeated failure“ to mean “In excess of 2% of claims.” (Hill) Delete ”at all times;” reference the “end of month. (Hill)	(d) This notification period is unrealistic. (Phoenix)	
		(e) Permit the external party to make any examination that it deems necessary to determine whether the organization is meeting the criteria of Rule 1300.75.4.2, and provide to the external party, upon request, any books or records that the external party deems relevant for inspection and copying. Rule 1300.75.4.3 (e).		(e) Include language that “audits must be conducted in a manner to avoid duplication,” outline the scope of audit request, include confidentiality protections, require “just cause” before requesting audits and a procedure for appealing a request for an audit. (Brown) This section is extremely broad – additional information should be limited to requests deemed reasonable and necessary by the director. (CMA) Curtail the unlimited power grant the external party. (Hill)	(e) This section should specify the frequency and nature of the external party’s periodic audits. (2CCS)	

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		(f) Allow the plan to terminate the contract if the organization has failed to provide the reports or notices, or has failed to permit an examination by the external party, as required by this rule. Rule 1300.75.4.3 (f).		(f)Limit termination rights to repeated violations (that are substantial and serious breaches); include a notification and cure period; include a mediation provision to resolve disputes relating to compliance with this section. (Brown/CMA) Termination should be limited to failures that are material, willful and knowing and which substantially impairs the plans ability to furnish or arrange for health care services for its EES. (CMA) *General Comments:* The specificity of the financial review is not workable or equitable. (AMGA) The law does not require these provisions to be contractual; if they are to be set forth in a contract, a mechanism must be established to ensure the requirements are uniform and standardized. (CMA) Insert a provision prohibiting plans from requiring additional financial information by contract. (CMA)	(f) Termination is too severe and one-sided and should require a "finding" of a failure to submit before termination. (Phoenix)	

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Org Eval/Corrective Action/Plan Reporting	**ORGANIZATIONAL EVALUATION** For every contract between a risk bearing organization and a plan: 1. The risk bearing organization must furnish financial information to the plan and meet other financial requirements that assist the plan in maintaining the financial viability of its arrangements for the provision of health care services.	(a) Every contract between a plan and an organization shall require the organization to comply with a process administered by the external party to review or grade the organization. The contract shall also require the organization, as part of this process, to do all of the following: (1) Permit the external party to perform any of the following activities: (A) Obtain and evaluate information pertaining to the organization's performance in meeting the criteria of Rule 1300.75.4.2. (B) Prepare periodic reports describing the organization's overall performance in meeting the criteria of Rule 1300.75.4.2 and comparing the overall performance of all organizations. (C) Maintain a public file of reports and nonproprietary information concerning the organization and make the reports and information available to plans, organizations, the Department, and other interested parties.	(a) Latitude for delegation is too great, and there is greater need for guidance. (CAHP/HMOT) Clarify requirements for "failure," and purpose of external party. The plan requires greater authority to obtain financial information needed to fully evaluate the organization if it is their responsibility to determine compliance. (CAHP/HMOT) Clarify nature of grading and rating, and determining solvency, i.e. on a sliding scale. (LHPC) (C) clarify description of reports, documents and information to be publicly available. (LHPC)	(a) Define the scope of "process." (Brown) Delete the words "all of" before the word "the following:" (AMGA) (a)(1) delete "any of" (AMGA) Include no duplication language. (Brown) (a)(1)(A) define the scope of the information that may be requested. (Brown) (a)(1)(B) define "periodic;" provide an appeals procedure to challenge the reporting results. (Brown) (C) The external party should maintain confidential not public files. (AMGA) Provide an opportunity for the organization to verify that submitted information is non-proprietary. (Brown/CMA)	These regulations should provide for routine periodic onsite verification of the information provided by risk-bearing organizations. (2CCS)	

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				Define proprietary information in specific detail. (CMA /Hill)		
		(2) Allow the plan to terminate the contract if the organization has failed to comply with the evaluation process or has failed to permit the activities of the external party, as required by this subsection.		(a)(2) add "with proper notice and cure" after "terminate contract" (AMGA/Brown/Hill) Limit remedy to repeated/material violations and provide a mediation process to resolve disputes to avoid plan abuses. (Brown/CMA)		
		(b) Every plan that contracts with an organization shall have adequate procedures in place to ensure that the plan:		(b) Who monitors and ensures that plans have "adequate procedures?" (Brown) The Department should be responsible for ensuring that plans maintain "adequate procedures." (CMA)		
		(1) Reviews any reports and nonproprietary information made available by the external party, to determine whether or not all of the plan's organizations are meeting the criteria of Rule 1300.75.4.2.				
		(2) Notifies the external party no later than one (1) business day from discovering that any of its organizations have allowed (A) any repeated failure to reimburse, contest, or deny claims, or to estimate incurred but unreported claims, in accordance with Rule 1300.75.4.2, or (B) any failure to maintain, at all times, minimum tangible net equity or minimum working capital, in accordance with Rule 1300.75.4.2.		(b)(2) 1 business day is unreasonable; change to 30 days AMGA/5 business days. (Brown/ Hill) Delete "at all times." (AMGA) *General Comments:* This section is duplicative and unnecessary - either delete or streamline. (CMA)	(b)(2) Notification within 1 business day is not realistic. (2CCS)	

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	CORRECTIVE ACTION A process for corrective action plans, as mutually agreed upon by the plan and the risk bearing organization and as approved by the director, for cases where the review or grading indicates deficiencies that need to be corrected by the risk-bearing organization, and contingency plans to ensure the delivery of health care services if the corrective action plan fails. The corrective action plan should be standardized, to the extent possible , to meet the needs of the director and all plans contracting with the risk-bearing entity. Sec. 1375.4(b)(4).	(a) Every contract between a plan and an organization shall require the plan and the organization to comply with a process administered by the external party for corrective action plans. The contract shall also require the plan and the organization, as part of this process, to do all of the following: (1) Propose recommendations for corrective action upon request of the external party. (2) Meet with and advise the external party regarding the recommended corrective action, upon request of the external party. (3) Permit the external party to prepare a corrective action plan, taking into consideration the recommendations of the plan and the organization. (4) Resolve any disputes concerning the corrective action plan pursuant to a resolution mechanism established by the external party. (5) Allow the Director up to five (5) business days from receipt of the corrective action plan from the external party (or longer period if deemed necessary by the Director), to inform the external party that the corrective action plan is either approved without modifications or	(a) Statement suggesting third party will create corrective action plan is inconsistent with the statute. (CAHP/HMOT/PC) Responsibility should lay with the plan or Department. Specify timeframe to resolve disputes, and a deadline related to date of discovery for corrective actions. (CAHP/HMOT) Role of external party should be circumscribed, no more than the delegation authority of the Director. Maintain flexibility of CAP arrangements. (PC) (5) Specify scope of actions that may be taken by the Director. (CAHP/HMOT) Allow FSSB to provide copies of all corrective actions to plans with which an organization currently contracts. (LHPC)	(a) Delete “all of.” (AMGA) Both the plan and the organization should participate in drafting the corrective action plan as the plan is required to be “mutually agreed upon” and approved by the director and standardized. (Brown/CMA) (a)(3), (4) & (5) These provisions may greatly impact the risk organizations if they are unable to convince the external party of the negative impact of the plan that is proposed. (Hill) (a)(3) Insert “single” after “prepare a.” (AMGA/CMA) (a)(4)To avoid conflicts, the resolution mechanism should be defined in the reg. not by the external party. (Brown)	(a)(5)Extend the time limit for the director to approve the corrective action plan to a more realistic length. (2CCS)	

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		approved subject to any modifications, including standardization, that the Director deems appropriate to meet the needs of the Director and all plans contracting with the organization. (6) Terminate the contract if the organization has failed to comply with the corrective action process, or if the organization has failed to take corrective action or to meet the requirements of Rule 1300.75.4.2 in accordance with the approved corrective action plan.	(6) Termination "requirement" conflicts with more permissive language in the statute, and should be "allowed" at plans discretion. (CAHP/HMOT/LHPC) Suggest adding, "Plans assume liability for incurred and unpaid services if it decides to not terminate." (LHPC)	(6) Add "proper notice and cure" following "terminate the contract" (AMGA/Brown) Remedy should be limited to repeated violations; a mediation process to resolve disputes should be included. (Brown) Delete mandatory language relating to termination and insert discretionary language for mitigating circumstances or non-material issues. (CMA/Hill) Adopt more specific language such as: "When a risk bearing provider organization is unable to meet a corrective action plan, further actions may be implemented up to and including a contingency plan for each organization to ensure continuity of care of enrollees consistent with the KKA. The contingency plan shall include written details for contracting with the organization and payment to individual providers to ensure continuity of care with individual providers (on a fee-for-service and/or capitated basis), contract provisions to		

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				extend the ongoing treatment of a plan's enrollee, and other arrangements to ensure that health care services to the enrollees will not be interrupted." (CMA) Insert an appeals process to the Department before termination. (CMA)		
		(7) Adhere to any contingency plan (as set forth in the approved corrective action plan) for the continuous delivery of health care services to the plan's enrollees, if the organization's corrective action fails. Rule 1300.75.4.5(a)(1)-(7).	(7) "Adherence" is too strict a term, as plans may change along with circumstances. (CAHP/HMOT)	(7) Delete "adhere to" and insert "Substantially comply with". (Brown) This requirement should be limited to contingency plans that have been agreed to advance. (Hill)		
		(b) Every plan that contracts with an organization shall have adequate procedures in place to assure that the plan complies with the corrective action process and cooperates in the implementation of an approved corrective action plan. Rule 1300.75.4.5(b).	(b) Plans require authority to obtain needed data and to obtain corrective action plans that the organization may have with other health plans. The Department should provide standard formats for corrective action plans. (CAHP/HMOT) Requiring plans to terminate contracts with an organization is inconsistent with similar provisions. Plans should be allowed, not required to do so. Suggest plans may continue contracts but take back previously delegated functions. (PC) Clarify compliance with corrective action plans is responsibility of FSSB not health plans notwithstanding any	(b) Require the Department to ensure that plans have adequate procedures in place. (CMA)		

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			requirement that plans monitor written exchange between organizations and FSSB and report non-compliant conditions to FSSB. (LHPC/CAP)	*General Comments:* Revise section so that the physician organization is to "cooperate with the mutually agreed upon" contingency plan to insure that patient care is maintained. (AMGA)		

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	Plan Reporting Periodic reports from each health care service plan to the director that include information concerning the risk-bearing organizations and the type and amount of financial risk assumed by the, and, if deemed necessary and appropriate by the director, a registration process for risk-bearing organizations. Sec. 1375.4(b)(6).	(a) Every plan that contracts with an organization shall, not more than forty-five (45) days after the close of each quarter of its fiscal year, submit a report to the Director containing a list of all its contracting organizations including their names, addresses, contact persons, and telephone numbers, and describing all risk-sharing arrangements with each organization in a manner that enables the Director to determine the type and amount of financial risk assumed by each organization including, at a minimum, the following information for each and every risk-sharing arrangement: (1) The nature of the risk-sharing arrangement. (2) The purpose of the risk-sharing arrangement. (3) The method for determining each and every amount (including expenses and income) allocated to the organization and to the plan under the risk-sharing arrangement. (4) A separate explanation of the method of calculating each and every amount allocated to the organization and to the plan for the provision of any pharmacy services under the risk-sharing arrangement. (5). The time period for the risk-sharing arrangement.	(a) Require plans to submit information about organizations only once and then periodically, i.e. every 6 months, as the information is also in contracts submitted to the Department. (CAHP/HMOT/PC) (a) Change quarterly reporting to annual reporting to avoid onerous, redundant work for organizations. (SFHP) Many items requested by Department are proprietary and should be filed as confidential. (PC) Include requirement to submit lists of organizations added or deleted quarterly, and no report required unless previous filing information changes. Also, plans not required to submit descriptions of risk-sharing arrangements with those organizations as they are already submitted to Department. (LHPC) (3) Clarify “method of determining each and every amount,” and “any problem” experienced by the plan or the organization regarding risk-sharing arrangement. Plans should not have to report all problems or may be unaware of the organization’s reasons for problems, i.e. interpreting benefits guidelines, computer interface problems, etc. (CAHP/HMOT)	This section needs to set out remedies and consequences for lack of compliance by the plan. (Brown) (a) Reporting should be annual, as the arrangement does normally change quarterly. (Brown) Insert a requirement that Plans report the actuarial soundness of their risk sharing arrangements. (CMA)		

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		(6) Each and every amount allocated to the organization and to the plan under the risk-sharing arrangement.			(6) This requirement is too burdensome, unnecessary, costly and will not provide valuable information not already required to be provided to providers in Reg. 1300.75.4.1 (a)(4). (2CCS)	
		(7) Any problem experienced by either the plan or the organization with respect to the risk-sharing arrangement and, for each problem, a description of any action taken to correct that problem together with an explanation of the results of that action. Rule 1300.75.4.6(a)(1)-(7).	(7) Clarify "any" reportable problems. (SFHP) Clarify threshold for reporting, i.e., reportable problems are those that may result in adverse risks to either health plan or organization of over $50,000. Clarify conditions stated for liability accruing to the health plan for any incurred but unpaid services from providers pursuant an agreement between provider and organization. (LHPC)		(7) This section lacks specificity and should require the reporting of the most current information**.** **(**2CCS)	
		(b) Each quarterly report shall specify the plan's name, the quarter and date of report. In addition each quarterly report shall be signed by a person authorized to do so by the plan, verified, and filed along with two copies of the report, in the Department's Sacramento Office to the attention of the Health Plan Filing Clerk. The quarterly report need not be filed as an amendment to the plan application. Rule 1300.75.4.6(b).		(b) All disclosures made pursuant to this section should be deemed confidential and proprietary information. (Brown)		
		(c) Upon request, the plan shall provide any additional information				

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		that the Director may from time to time require to understand the type, amount, or appropriateness, of the financial risk assumed by the plan's organizations. Rule 1300.75.4.6(c).	*General Comments:* Compliance should constitute compliance with the plans obligations under 1375.1(a) (3) (CAHP/HMOT) Funding should come from licensing fees applied to all health care service plans including specialized plans and not limited to full service health care service plan. (CAHP/HMOT) Overall costs too high as are paperwork burdens. (CAHP/HMOT) 1300.75.4.8 Do not exempt specialized plans from sharing administrative costs. Clarify method for allocating administrative among health plans; suggest costs be based on plan size, and number of medical groups contracted with a plan. (SFHP) Concur with CA Assn. of Health Plan comments. (PC) Delay effective date of at least one year, as needed for compliance and submission any modified contracts to Department. (PC)	*General Comments:* Without a requirement that plans report the actuarial soundness of their rates, Section 1300.75.4.7(a) [Plan Compliance] is inconsistent with the KKA. It elevates form over substance. (CMA)		

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			Clarify method for determining administrative costs among plans; Suggest basing upon combination of number of IPAs contracted by plan and covered lives subject to risk-sharing arrangements. (LHPC)			

Public Comments by:
John F. Alksne (Alksne)
American Medical Group Association, California Association of Physician Organizations and National IPA Coalition (AMGA)
Brown & Toland (Brown)
California Medical Association (CMA)
CapMetrics (CAP)
Health Access (HA)
Health Administration Responsibility Project, Inc. (HARP)
Hill Physicians Medical Group, Inc. (Hill)
Hyde, Miller, Owen & Trost (HMOT)
Kaiser Foundation Health Plan, Inc. (Kaiser)
Paul M. Katz (Katz)
Local Health Plans of California (LHPC)
PacificCare of California (PC)
San Francisco Health Plan (SFHP)
2C Compliance Solutions (2CCS)
Valley Health Plan (VHP)
Vision Plan of America (VPA)
Phoenix Healthcare Consulting (Phoenix)