AMERICA'S PHYSICIAN GROUPS
Taking Responsibility for America's Health

November 17, 2020

Mary Watanabe, Acting Director
Members of the Financial Solvency Standards Board
Department of Managed Health Care
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Sent electronically

Re: Financial Solvency Standards Board, APG Observations and Suggestions

Dear Ms. Watanabe:

As we close on 2020 and a new FSSB board is appointed by the Director, America's Physician Groups would like to provide some observations on the operation of the Financial Solvency Standards Board and some suggestions for its future.[1]

Purpose of the Financial Solvency Standards Board: During the 1999 legislative session the SB 260 bill (Speier, 1999) was passed and signed into law requiring the newly formed Department of Managed Health Care to review the financial solvency of delegated, risk-bearing medical providers and to create the Financial Solvency Standards Board to advise the Director on matters of financial solvency affecting the delivery of health care services (Health & Safety Code Section 1347.15(b)(1)). According to a later summary presented at the January 29, 2002 FSSB Meeting: **"One of the specific charges given to the Board was to study and report to the Director regarding 'The appropriateness of different risk-bearing arrangements between health plans and risk-bearing organizations.'"**[2]

Historical Performance of RBOs under SB 260 Financial Solvency Reporting: APG conducted a review of the entire archive of quarterly staff reports given at FSSB meetings, including the minutes and the provider solvency report slides for each meeting. The result shows that in the early days of the new SB 260 scheme, almost 50% of the RBOs in California reported one or more deficiencies. Since then the average number of RBOs meeting compliance with the four criteria has levelled out to about 90% over the past decade. What is more remarkable is the effective way the combination of the new solvency standard, coupled with diligent staff oversight has greatly *decreased* the number of closures due to insolvency. There was one month during 2001 or 2002 when I recall that 20 RBOs closed due to insolvency. There have

[1] *APG confirms that this is a public submittal to the Department.*

[2] *Overview of Risk-Sharing Arrangements, Prepared for the FSSB Meeting January 29, 2002. Obtained at: https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/FSSB/Meetings/a020129_info.pdf.*

been no instances of sudden closures such as those experienced in the 1998 to 2002-time frame that led to passage of the Continuity of Care Act and Block Transfer Regulation, implemented in 2004.

The Department has recently updated the initial SB 260 solvency and reporting requirements through further regulation, and we hope this new structure will build upon the past 15 years of stability within the RBO community. The Department deserves kudos for its track record in monitoring the risk-bearing provider model.

Current Environmental State: There are many new challenges to RBO financial solvency:

- The increasing tendency of health plans to unilaterally shift new and un-negotiated financial risk to RBOs during the term of a contract for new drugs and treatments, in contravention to the spirit and letter of the Provider Bill of Rights
- The use of ambiguous Division of Financial Responsibility documents that contain loopholes large enough to drive a bus full of highly compensated health plan executives through
- The use of the delegated model in Medi-Cal managed care at lower capitated rates and greater administrative overhead
- Continuous annual addition of administrative requirements upon risk-bearing providers, including over 200 cumulative statutes enacted from 1998 to the present
- The need by smaller physician organizations for greater administrative scale to keep up with new regulatory compliance requirements and the overall complexity of the healthcare system that requires contracting with large, capable MSOs
- The ongoing uncertainty of the future impact of the Coronavirus pandemic on employer-sponsored coverage, health care workforce, and Medi-Cal enrollment

There is a need for continuous balancing of policy objectives between affordability, access, and compliance within the administration of the Knox Keene Act so that providers can remain solvent, stable, and improve the delivery of care to Californians. This is exactly why the FSSB was formed under the initial legislation, to provide the Department with insight and advice on that balancing effort.

Suggestions for the future direction of the FSSB: In our review of the past 15 years of archived meeting reports, we have noticed gaps that could be improved so that the Board can be provided with a broader picture of RBO performance:

- Historic reporting has focused on non-compliant RBO performance, but it lacks any usable information on the root causes that lead to financial instability. The Department recently added MSO affiliation to the corrective action plan summary list of non-compliant RBOs. We strongly recommend adding health plan affiliation as well. It is not difficult to link the data on contracted health plans for each RBO that is contained in the Statement of Organization maintained by the Department.

- **Create a scoring system for the financial solvency of RBOs**. We suggest that each RBO is scored based on the number of quarters that it has been active, over the number of quarters that it has been compliant with all four criteria. For example, Acme RBO has been active for 40 quarters, and was compliant during 38 of those quarters. Its score is 40/38. This kind of scoring mechanism presents more of a historical perspective on the overall stability of the provider organization and its ability to sustain risk.

- **Conduct reviews by the case study method of chronic non-compliant RBOs**, so that the Board has information relevant to give advice to the Department on management, oversight and payment elements that would improve the rate of compliance with the solvency standards. And do the same for organizations that have reported years of stability and compliance as well. Case study method does not require naming specific organizations if the Department has concerns over privacy.

- **Report quarterly on any closures of groups when an existing RBO goes inactive, or merges.** In our review of 15 years of staff reports at FSSB meetings, there wasn't any substantial discussion of a closure, or consolidation – and yet these two areas are very important to assessing the state of risk bearing providers in California. This kind of reporting could lead to further examination of the underlying causes of provider consolidation across California, and its extent.

- **Relate the AMP quality scores of groups under CAP**. This correlation was cited in the original CAP Metrics study presented to the FSSB in 2002.[3] CapMetrics analyzed the 50 RBO closures that occurred between 1997 to 2002 and found a direct correlation between groups that performed at lower quality levels and financial instability.

- **Report on surveys directed toward the RBO model**. The Department is conducting more frequent surveys of the delegated model. Recently, it studied AB 72 payments and is currently developing a survey on practice closures during COVID. The Department also annually discloses audit findings on the delegated model but has not included discussion at FSSB meetings.

- **Study the current state of DOFR integrity by inviting a panel of health plan and RBO participants**. Recent activities by health plans to unilaterally shift risk during the term of a risk bearing contract for new drugs and treatments affect the financial stability of RBOs. This trend is not considered when RBOs fall onto the CAP list. Also, it would be helpful to study the impact of unilateral plan waiver of provider copays without reimbursement for the loss of total negotiated capitation revenue during the Pandemic. Over 16,000 physician practices have closed across the nation during the pandemic. The

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[3] *CapMetrics, Aug. 2002: located at: https://collections.nlm.nih.gov/master/borndig/101210147/California%20physician%20group%20solvency%20standards.pdf..*

unilateral waiver of copay revenue, without backfill, contributed to this unfortunate situation. Invite ICE to present on its automated DOFR project.

- As the OSHP HPD becomes active, invite OSHP staff to present at least once annually on data and metrics developed under the claims database

- At least once annually, provide an update on efforts to improve encounter data reporting accuracy at the plan and provider level

- Study the impact of the Medi-Cal drug carve out on capitation rates and DOFR administration, including its impact on RBO financial solvency

- Provide an annual summary of the prior calendar year that succinctly summarizes the following information:

    - Total number of RBOs at beginning and end of calendar year
    - Number of new RBOs that became active
    - Number of RBOs that closed, merged, or were rolled-up into joint reporting, with a summary of the activity, like Cattaneo & Stroud reporting
    - The number of CAPs opened, resolved, and closed during the year
    - The number of groups on CAP during the year, and their status
    - Percent of groups compliant and non-compliant at the end of year

The Department's continued operation of the Financial Solvency Standards Board has presented a valuable forum for discussion about the condition of the health care market. We look forward to many future meetings of this important advisory body.

Respectfully submitted,

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