AMERICA'S PHYSICIAN GROUPS

CONTRACTS COMMITTEE

NOVEMBER 7, 2018

LOS ANGELES, CALIFORNIA

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HOUSEKEEPING ITEMS FOR PEOPLE ON WEBEX

- You can download the materials from the APG member-only website post-meeting.
- Please do not put us on hold. We cannot talk over the hold music.
- Please mute your line. We will mute your line if you are too noisy.

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TODAY'S AGENDA

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- Introductions by Committee Chairs, **Jim Agronick**, Regional VP, Adventist Health Physicians Network and **Don Comstock**, Comstock & Associates, Managed Care Consulting
- *Direct-Employer Contract- What Do You Need to Know*, **Brad Byars**, COO, Providence Health Network
- *APG Member Suggested Topics, Questions, and FYIs*
- *APG Updates*, **Bill Barcellona**, Senior VP Government Affairs, APG

LUNCH

- *DMHC Updates*, **Mary Watanabe**, Deputy Director, Health Policy and Stakeholder Relations and **Pritika Dutt**, Deputy Director, Office of Financial Review
  - *Topics*: timely access, provider directory utilities, SB 137 and 72, Restricted License, and RBO examination process and coordination with health plans
- *California Policy Updates*, **Bill Barcellona**, Senior VP Government Affairs, APG
- New Business

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DIRECT-EMPLOYER CONTRACT - WHAT DO YOU NEED TO KNOW

BRAD BYARS

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TOPICS, QUESTIONS, & FYI

- PMPM Cost Database by Categories
- Anesthesiology Issue – St. Joe's
- Medicaid – Medicare Advantage Reclamation Issue – Riverside Medical Clinic

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APG UPDATES

PHYSICIAN GROUPS

New APG Website: Member-Only Access

- Requires a log-in
- Committee agenda, presentation, summaries, handouts
- Member information
- Calendar of Events
- Ad hoc WebEx
  - Deep Dives on policy changes
- Annette Sanchez, Asanchez@apg.org

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APG Colloquium Summary

Keynote Address by Senator Whitehouse

"this type of (middle of the pack) policymaking fails to drive and reward the change we need in our healthcare system. …Feed the lead dogs… Need to reward the leader"

Video from the APG Colloquium

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Topics-Speakers

- *Social Determinants of Health*- Geisinger and SCAN Health Plan
- *Healthcare Media*- Washington Post, Politico, Becker's Hospital Review
- *Accountability into Healthcare*- National Business Group on Health and America's Health Insurance Plan
- *Fireside Chat with CMS*- Pauline Lapin, MHS, Group Director, CMMI
- Medicare ACOs- former Deputy Administrator for CMMI
- Pearls of Wisdom from 5 Capitated Groups

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Connecting the Dots: How Open Data, APIs, Care Model Code Can Fuel Value-Based Care Delivery

- Aneesh Chopra
  - Chief Technology Officer under President Obama
  - President, CareJourney
- Blue Button
  - Allows all Medicare members to access their own data regardless where they are seeking care
- Enablers for Digital Transformation
  - Invest in (digital) infrastructure
  - Encourage standards
  - Open up data
  - Enable "retail" and "wholesale" digital services
  - Reward outcomes

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Risk Evolution Task Force

- Open to APG members only
- Support the accelerating of the **volume → value** movement
- Provide education and support
- Lead by subject matter experts
  - Aneesh Chopra, MPP- President of CareJourney, former US CTO
  - Eric Coleman, MD, MPH- Founder of The Care Transitions Program, Professor of Medicine, Head of Division of Health Care Policy and Research at the University of Colorado Anschultz Medical Campus
- Stay tune for more information
- Contact Valinda Rutledge, VP Federal Affairs, vrutledge@apg.org

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- **Educational Series for APG Members Only**
  - 2:00 – 3:00 PM EST
  - Deep dives discussion on CPC+, MA Value Based Insurance Design (VBID) models, ACO rules, etc.
- **Dates**
  - ✓ July 10th – *Other Payer Advanced APMs;* Michail Reiche, Executive Director of Medicare Accountable Care for Steward health and Tamara Schaffert, COO for Physicians of SW Washington
  - ✓ August 8th – *Medicare Advantage Value-Based Insurance Design (VBID) model;* Danielle Lloyd, SVP of AHIP, Greg Jones, Senior Director of Public Policy of Aetna, Dr. Mark Fendrick, University of Michigan Professor of Internal Medicine and Health Management and Policy
  - ✓ September 5th- *Deeper Dive into the New MSSP ACO Changes*; Aneesh Chopra, President of Care Journey
  - November 14th - TBD
  - December 12th - TBD
- **Valinda Rutledge, VP of Federal Affairs, APG,** VRutledge@apg.org

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Standard of Excellence™ (SOE®) Elite Recipients

- 122 physician organization participated with 11 first-timers
- Cared for 12.9 million commercial lives; 3.2 million Medicare Advantage lives; 3.7 million Medicaid lives
- 87 physician organizations achieved the Elite Status- 6 new members
- Met benchmark in 5 domains of the SOE Survey
  1. Care Management Practices
  2. Information Technology
  3. Accountability and Transparency
  4. Patient-Centered Care
  5. Group Support of Advanced Primary Care

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CASE STUDIES IN EXCELLENCE 2018

- Highly effective tool to demonstrate what our coordinated care systems can accomplish through innovation
- Publication features select examples of creative and effective programs implemented by APG members
- Education through sharing of best practices

Download at www.apg.org/casestudies

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FUTURE EVENTS

Jan 8: HR Committee
Jan 9: Webinar Wednesday
Jan 15: APM WebEx
Jan 22: I AM APG Advocacy
Jan 24: San Diego Regional
Jan 31: Northern CA Regional

Feb 5: Northwest Regional
Feb 12: Contracts Committee
Feb 13: General Membership
Feb 13: Webinar Wednesday
Feb 20: Pharmaceutical Care
Feb 21: Federal Policy WebEx
Feb 21: Hawaii Regional Meeting

Mar 5: Southwest Regional
Mar 12: APM WebEx
Mar 13: Webinar Wednesday
Mar 14: HR Committee
Mar 19: Southeast Regional
Mar 26: PR/Marketing Committee
Mar 26: Inland Empire Regional

Apr 10: I AM APG Advocacy
Apr 11-13: Annual Conference
San Diego, CA
Apr 11:Clinical Quality Leadership
Apr 30: Colorado Regional

Visit APG website for updated locations and dates, www.apg.org

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DMHC UPDATE

MARY WATANABE & PRITIKA DUTT

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APG Contracts Committee Meeting

November 7, 2017

Mary Watanabe
Deputy Director, Health Policy & Stakeholder Relations
Pritika Dutt
Deputy Director, Office of Financial Review

Agenda

1. DMHC Priorities for 2019
2. Regulations Update
3. RBO Examination Process
4. RBOs on Corrective Action Plans
5. Questions

DMHC Priorities for 2019

- Provider Directories
- Timely Access to Care
- Prescription Drug Costs (SB 17)
- Oversight of Delegates
- Mergers & Acquisitions

Provider Directories

- SB 137 (Hernandez)
  - Set standards for provider directories
- Uniform Provider Directory Standards
  - Initial standards released: December 31, 2016
  - Compliance date: January 1, 2018
  - Final Regulations: January 1, 2021
- Provider Directory Utility

Timely Access to Care

- MY 2017 Report
- MY 2018 Data Collection
- MY 2019 Improvements

SB 17 (Hernandez) Prescription Drug Costs

- Health plans must report by October 1, 2018 and annually thereafter to the DMHC:
  - 25 most frequently prescribed drugs
  - 25 most costly drugs by total annual spending
  - 25 drugs with highest year-over-year increase in total annual spending
- DMHC will issue a report to Legislature with aggregate data beginning January 1, 2019 and annually thereafter

Oversight of Delegated Entities

- Holding plans accountable for the behavior of their delegates
- "Delegates" broadly defined
  - Includes all entities that are delegated responsibility for Knox Keene Act-regulated functions, not just RBOs
- Evaluating revisions to survey and exam processes
- Evaluating needed statutory and regulatory revisions

Mergers & Acquisitions

- **Merger Mania 2.0**
  - Optum/DaVita
  - CVS/Aetna
  - Cigna/Express Scripts
- **Impact of AB 595**

Regulations - 2018

- Risk and Restricted License (General Licensure)
- Average Contracted Rate Methodology (AB 72)
- Risk Bearing Organization (RBO) Requirements (Financial Solvency)
- Cancellations, Rescissions and Non-renewals (AB 2470)
- Standard Formulary Template (SB 1052)

Regulations – 2019 and Beyond

- Timely Access Methodology
- Large Group Rates (SB 546) and Prescription Drug Cost Transparency (SB 17)
- Provider Directories (SB 137)
- Prescription Drug Tiering (AB 339)
- Out-of-Pocket Maximum Tracking

AB 72 Overview

Effective July 1, 2017:

- Prohibits Surprise Balance Billing.
- Establishes a Default Reimbursement Rate.

Effective September 1, 2017:

- Establishes a binding and mandatory Independent Dispute. Resolution Process (IDRP). Access to legal remedies is preserved.

Effective January 1, 2019:

- Requires the DMHC to finalize regulations establishing a standard Average Contracted Rate (ACR) methodology.

Standardized Methodology

DMHC developed a standardized methodology for calculating the average contracted rate (ACR). The regulation was approved by the Office of Administrative Law (OAL) on September 13, 2018 and takes effect on January 1, 2019.

- Plans and delegated entities must use this methodology to calculate the average contracted rate for services rendered on or after January 1, 2019 and most frequently subject to Health and Safety Code Section 1371.9.
- Plans and delegated entities are still required to pay the greater of 125% of Medicare or the Average Contracted Rate.

Definitions

"Average Contracted Rate"

The ***claims-volume weighted average*** of the contracted commercial rates paid by the payor for the same or similar services in the geographic region, in the applicable calendar year, for services most frequently subject to section 1371.9 of the Knox-Keene Act. The applicable calendar year is ***two years prior*** to the year in which the health care service was rendered.

ACR Calculation

Weighted mean

$$ACR = \frac{\text{sum (contract rate x \# of claims paid at rate)}}{\text{total number of claims}}$$

Example

Allowed Amount: Contract A ($10), Contract B ($15), and Contract C ($12)

Number of Claims – Contract A (25), Contract B (30), and Contract C (45)

$$\text{Weighted ACR} = \frac{(\$10 \times 25 + \$15 \times 30 + \$12 \times 45)}{100} = \$12.40$$

Definitions

"Default Reimbursement Rate"

The greater of the average contracted rate or 125 percent of the Medicare rate, payable to a noncontracting individual health professional pursuant to section 1371.31 of the Knox-Keene Act.

"Medicare Rate"

The amount Medicare reimburses on a fee-for service basis for the same or similar health care services in the geographic region in which the health care services were rendered, for the calendar year in which the health care service was rendered, on a ***"par" basis***. "Par" basis means the reimbursement rate paid to health care service providers participating in the Medicare program by accepting Medicare assignment.

Definitions

"Services Most Frequently Subject to Section 1371.9"

The health care services that, when added together, comprise at least ***80 percent*** of the payor's statewide claims volume for health care services subject to section 1371.9 in the applicable calendar year.

"Services Subject to Section 1371.9"

Nonemergency health care services provided to an enrollee by a noncontracting individual health professional at a contracting health facility where the enrollee received covered health care services, or nonemergency health care services provided to the enrollee by a noncontracting individual health professional as a result of covered health care services received at a contracting health facility.

Other Considerations

- ACR must include the highest and lowest contracted rates.
- The ACR will take into account:
  - Health Care Service Code, including but not limited to CPT codes
  - Geographic Region – Medicare fee-for-service regions
  - Provider Type and Specialty
  - Facility type

Statistically Credible Database

Plans and delegated entities that do not pay a statistically significant number or dollar amount of claims for services covered under Section 1371.9, shall use a statistically credible database reflecting rates paid to noncontracting individual health professionals for services provided in a geographic region.

Statistically Credible Database

Plans and delegated entities will file policies and procedures with the DMHC demonstrating access to a statistically credible database, including:

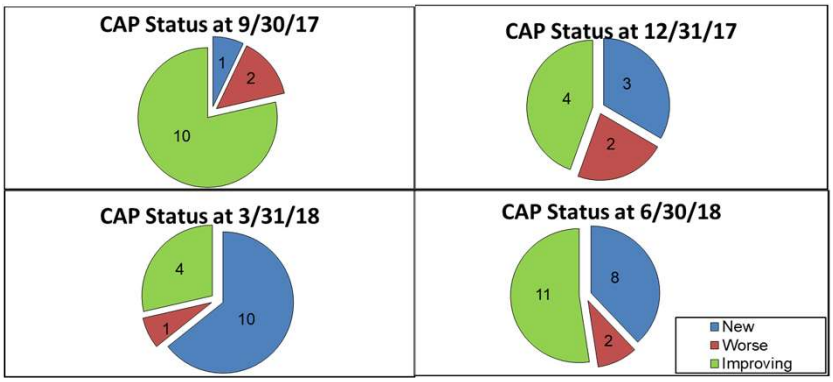
- An explanation and justification that, based on the plan or delegated entity's model, they do not pay a statistically significant number or dollar amount of claims for services covered under Section 1371.9.
- Information regarding the database that will be used to determine the ACR.
- Certification that the database is statistically credible.
- Explanation of percentile or methodology to determine the ACR.

RBO Examination Process

Changes to the RBO examination process include:

- Increased communication with RBO's contracted health plans
- Final Reports and Corrective Action Process

Status of Corrective Action Plans by RBO



CAP Review Summary as of 6/30/18

RBO	Enrollment at FYE	Deficiency	CAP Review as of					
			QE 6/30/18	QE 3/31/18	QE 12/31/17	QE 9/30/17	QE 6/30/17	Year 2016
Accountable Health Care IPA	150k-200k	TNE,WC,CC	X	X	X	X	X	
Allied Physicians of California, A Professional Medical Corporation	200k+	CT	X					
Asian American Medical Group	5k-10k	CT				X	X	X
Bright Health Physicians of PIH	50k-75k	CT						X
Bright Health Physicians of PIH	50k-75k	WC						X
Cal Care IPA, Inc.	20k-30k	CT	X	X				
Children First Medical Group, Inc.	50k-75k	CT						X
Chinese Community Health Care Association	10k-15k	CT				X	X	X
College Health IPA	200k+	CT						X
DaVita Medical Associates California, Inc.	200k+	TNE	X	X				
Desert Valley Medical Group	0-5k	TNE,WC		X	X	X	X	X
Encompass Medical Group	0-5k	TNE,WC	X	X				
Facey Medical Foundation	75k-100k	WC					X	X
Family Care Specialists Medical Group	10k-15k	CT					X	
Fenix Health Medical Group	0-5k	TNE,WC						X
Health Connect Medical Group	0-5k	TNE,CC	X	X		X		
Horizon Valley Medical Group	15k-20k	TNE						X
Imperial Health Holdings, A Professional Medical Corporation	10k-15k	CT	X			X	X	
Independence Medical Group	100k-150k	TNE,WC						X
Jade Health Care Medical Group	10k-15k	TNE,WC,CC	X	X	X	X	X	X

Deficiency
CT – Claims Timeliness
CC – Cash-to-Claims Ratio
TNE – Tangible Net Equity
WC – Working Capital

CAP Review Summary as of 6/30/18

RBO	Enrollment at FYE	Deficiency	CAP Review as of					
			QE 6/30/18	QE 3/31/18	QE 12/31/17	QE 9/30/17	QE 6/30/17	Year 2016
Joseph M. Molina, M.D., Professional Corp.	75k-100k	TNE,WC	X					
Leisure World Managed Care	0-5k	TNE,WC	X	X				
Los Angeles Medical Center	15k-20k	CT	X	X				
Marin IPA	20-30k	CT				X	X	
Merit IPA (Meritage Medical Network)	0-5k	TNE,WC,CC			X	X	X	
Montage Medical Group	0-5k	TNE	X					
Nivano Physicians, Inc.	40k-50k	TNE,WC,CC	X	X	X	X	X	X
Northern California Physicians Care Network, Inc.	0-5k	TNE,WC,CC						X
Omnicare Medical Group	30k-40k	TNE,CC						X
Physicians Medical Group of San Jose	75k-100k	CT					X	X
Pioneer Provider Network	30k-40k	TNE,WC	X	X				
Qualcare Incorporated	0-5k	TNE	X	X	X			X
San Benito Medical Associates, Inc.	0-5k	CT	X					
San Bernardino Medical Group	10k-15k	TNE,CC	X	X				
Santa Clara County IPA	20k-30k	TNE						X
Sequoia Health IPA, Inc.	30k-40k	TNE,WC	X					
Southern California Children's Health Care Network, A Medical Group, Inc.	0-5k	CT	X					
Vantage Medical Group	200k+	CT	X	X				
Verity Medical Foundation	15k-20k	TNE,WC, CC,CT	X			X	X	X

Deficiency
CT – Claims Timeliness
CC – Cash-to-Claims Ratio
TNE – Tangible Net Equity
WC – Working Capital

Questions

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CaliforniaDMHC
@CADMHC
CaliforniaDMHC
HealthHelp.ca.gov
DEPARTMENT OF Managed HealthCare

CALIFORNIA POLICY UPDATE

BILL BARCELLONA

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LAWS THAT AFFECT PROVIDERS

NEW HEALTH LAWS FOR 2019

THE CALIFORNIA LEGISLATURE

Bills are introduced in January and finalized by October

They typically become effective by January 1 of the next year, although some have alternate implementation dates

The Assembly and Senate each have Health Committees with full-time consultant staff and assigned Legislators

Assembly Health Chair: Jim Wood, Dentist from Sonoma County

Senate Health Chair: Richard Pan, Physician from Sacramento County

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2018 LEGISLATIVE THEMES

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- The Legislature had significant concerns over the following issues in this past year's session, but not all of these areas were ultimately addressed:
- Single payer supporters lobbied hard for passage of SB 562, but it stalled
- Cost control advocates (labor union trusts and employers) worked to dismantle consolidated provider systems and create provider rate regulation
- The Legislature sought to address the opioid addiction problem through several bills
- Advocates for behavioral health integration and reform sponsored several bills
- Trump administration efforts to incorporate alternatives to the Affordable Care Act through short term plans were resisted, and made illegal in California

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MERGERS & ACQUISITIONS

- AB 595 (Wood)
- Gives the Department of Managed Health Care, a State agency with jurisdiction over all HMO business the authority to:
  - Conduct public hearings on health plan mergers with other entities
  - New standards for the consideration of mergers, such as whether they will produce lower health care premiums, or increase competition in the market
  - New authority to deny mergers that don't present increased value to the market
  - Becomes effective on January 1, 2019
  - Uncertainty over whether pending merger deals will be held until the new law becomes effective

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DRUG COSTS

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- AB 1860 (Limón)
- Copays and Coinsurance limits for prescribed, oral anticancer drugs will be limited to $250 per month
- Applies to all HMO and PPO plans in California, but not to self-insured employer plans (ERISA)
- Becomes effective for plan renewals after January 1, 2019 and sunsets on January 1, 2024

- AB 2863 (Nazarian)
- Pharmacists must inform a customer whether the retail price for a prescribed drug is lower than the applicable member cost-sharing amount
- Prohibits health plans from requiring copays or coinsurance amounts if the drug cost is lower than the applicable cost-sharing amount
- Becomes effective January 1, 2019

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PRESCRIBER REQUIREMENTS

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- AB 2789 (Wood)
- Electronic Prescribing
- All prescribers must be capable of electronic prescribing by January 1, 2022
- All prescriptions for controlled substances shall be transmitted electronically by January 1, 2022
- AB 2086 (Gallagher)
- All prescribers of controlled substances shall be allowed to review a Department of Justice list of patients for whom they are listed as being the prescriber under the CURES Database Access
- Becomes effective on January 1, 2019

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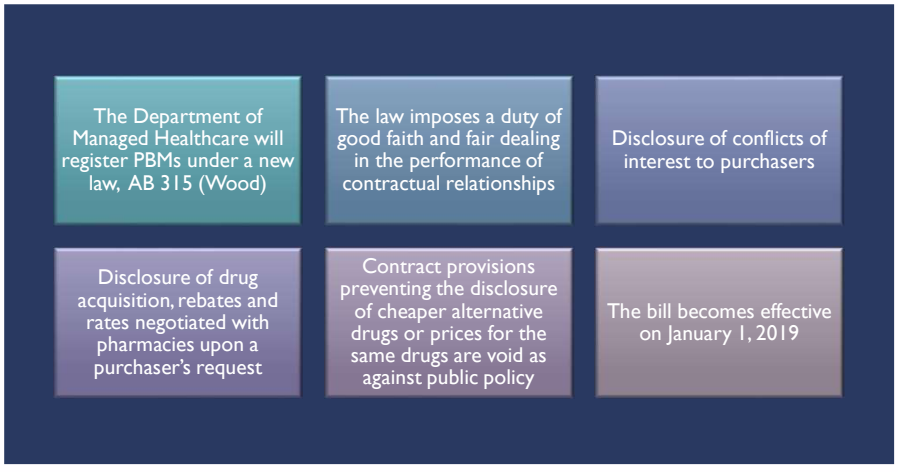

PHARMACY BENEFIT MANAGERS

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STATE OF EMERGENCY

- Health plans will be required to provide enrollees displaced during a declared state of emergency with access to medically necessary health care services
- Must file a plan within 48 hours describing how existing services have been impacted, how they will compensate, how they will communicate with enrollees, and how they will ensure continuity of care
- Relaxes time limits for authorizations, precertification or referrals
- Extends filing deadlines for claims
- Suspends prescription refill limitations, and includes out-of-network pharmacies
- Allows access to out-of-network providers
- Requires a toll-free telephone number for enrollee assistance with problems
- **Could become a delegated requirement for APG members from the Plan**

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HEALTH PLAN OVERSIGHT

- AB 2674 (Augiar-Curry) requires the Department of Managed Healthcare to review provider-generated complaints about unfair payment patterns on an annual basis
- Authorizes DMHC to conduct a special audit or enforcement action
- Becomes effective on July 1, 2019

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NETWORK ADEQUACY

Current Knox Keene Law requires 1 primary care physician for each 2,000 enrollees and 1 physician for every 1,200 enrollees. Prior legislation enacted in 2013 enabled a practice utilizing supervised, nonphysician medical practitioners to increase that ratio by an additional 1,000 lives. That legislation had a sunset provision.

→

SB 997(Monning) eliminates the sunset provision and makes the expansion of physician to enrollee ratio permanent. Nonphysician medical practitioners are defined as a physician assistant, certified nurse-midwife, or a nurse practitioner.

→

Thus, the bill enables small practices to greatly increase their value to managed care plans by adding significant additional capacity to the plan's network.

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SINGLE PAYER LEGISLATION STALLED

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- Single payer legislation (SB 562) passed the Senate but was held in the Assembly this past year
- A political alternative was considered and enacted under State Budget Legislation (AB 1810) to create a Council on Health Care Delivery Systems to review future models to achieve universal coverage for all Californians under a single, unified system. That same budget legislation also authorized the creation of an all-payer claims database at OSHPD within the next 3 years, to support any future system
- Additionally, AB 2472 (Wood) requires the Council to prepare a feasibility analysis on the creation of a public health insurance plan option (Public Option) to increase choice and competition for health care consumers. The analysis must be complete by October, 2021

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PROVIDER RATE REGULATION STALLED

- AB 3087 (Kalra) would have created a new, independent state agency to oversee the development of provider fee-for-service rates. Providers would have had to seek approval from this Commission to increase their rates and if they couldn't make a viable showing, their application would have been denied
- The bill also included complex provisions on the oversight of capitated payment and alluded to indexing it to Medicare Advantage, but upon questioning, the proponents really could not explain how that would work
- APG opposed the bill but worked with the author, Ash Kalra, to better understand how the capitated-delegated model works. The author agreed to hold the bill in Committee as other alternatives to cost control are considered

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APG MEMBER RESOURCES

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Taking Responsibility for America's Health

Provider Related Laws

1998 – Present

Contents:
Balanced Budget Act, California Legislative Assembly Bills and Senate Bills, and any other legislation that affects managed care patients

Notes:
- Bills are listed by the year in which they were enacted. Without specific references to operational dates, bills are effective January 1 of the year following enactment.
- Most code sections are referenced for chaptered bills. You can access a full version of the Knox Keene Act at www.dmhc.ca.gov/lawsregulations.aspx.
- Most bill numbers include blue hyperlinks to the bill's text in California Legislative Information's Bill Search function at leginfo.legislature.ca.gov.

Acknowledgement: Our deep appreciation to Epic Management, L.P., who created this summary and requested our help in updating and refining its content. We also acknowledge the thorough reviews and editing performed by Norma Springsteen of the APG Sacramento office.

APG Enacted California Health Laws
Bills Signed by the Governor in the 2018 Session

Behavioral Health

AB 2193 (Maienschein R) **Maternal mental health.**
Status: 9/26/2018-Approved by the Governor. Chaptered by Secretary of State - Chapter 755, Statutes of 2018.
Is Urgency: N
Summary:
Would require, by July 1, 2019, a licensed health care practitioner who provides prenatal or postpartum care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions.
Laws:
An act to add Section 1367.625 to, and to add Article 6 (commencing with Section 123640) to Chapter 2 of Part 2 of Division 106 to, the Health and Safety Code, and to add Section 10123.867 to the Insurance Code, relating to health care.

SB 192 (Beall D) **Mental Health Services Fund.**
Status: 9/10/2018-Approved by the Governor. Chaptered by Secretary of State. Chapter 328, Statutes of 2018.
Is Urgency: N
Summary:
This bill establishes a Mental Health Services Act (MHSA) Reversion Account for the purpose of depositing any MHSA funds allocated to a county that have not been spent for their authorized purpose, as specified. This bill establishes reporting and planning requirements for counties regarding

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EMERGING DEVELOPMENTS AFFECTING PROVIDERS

REGULATORY OUTLOOK

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REGULATIONS

- Regulations are developed by state agencies and departments to clarify and implement legislation
- While the Legislature creates statutory law, like the Knox Keene Act, it is implemented and clarified by the Department of Managed Health Care through regulations under Title 28 of the California Code of Regulations
- APG focuses on these two areas of legislation and regulation, as well as others that affect physician practice and Medi-Cal
- Regulations are developed differently than legislation, and they can be significantly more impactful to physician practice in California managed care

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- DMHC regulation still under development, but will likely implement the following:
- Greater transparency of complex relationships between plans and delegated physician groups
- RBOs are capitated physician groups that are delegated administrative functions by the plan, such as downstream claims payment of other providers, like ER services
- Will require higher amounts of capital to be infused into the RBO as a reserve and less reliance on sponsoring organizations, AR's, and IBNR
- Will require quarterly rather than annual compliance filings for smaller RBOs
- New filing forms that require greater detail on financial operations

RISK BEARING ORGANIZATION REGULATIONS

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NON-CONTRACTED PROVIDER PAYMENT

AB 72 and the subsequent regulation established a new standard for payment of non-contracted providers of non-emergent, facilities-based services to covered enrollees. This law banned patient balance billing for these services

A default payment rate of no less than 125% of the applicable Medicare Fee Schedule (typically applies to radiology and pathology)

An average contracted rate methodology by the plan or delegated RBO based on the final DMHC regulation (typically applies to anesthesiology)

A dispute resolution program operated by the DMHC in Sacramento to resolve payment disputes over the amount of the "average contracted rate."

DMHC will brief APG members at the November 7th Contracts Committee meeting in Los Angeles

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HEALTH PLAN LICENSURE

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- A regulation to formally establish the "Restricted License" in the Knox Keene Act – which includes Primecare, one of the original "Limited Licensees"
- RKKs, as they are referred to, accept global capitation from a fully-licensed health plan (both hospital and professional cap) and are fully-regulated by the DMHC, unlike RBOs, which are just monitored by the Department
- There has been a growing number of applications for RKK licenses and the Department wanted to formalize the process under regulation
- But the Department redefined "global risk" as broader than just hospital and professional capitation, to other kinds of global payments that are not capitated, and the industry does not understand how this will work
- The regulation may affect non-capitated ACOs in Medicare, and commercial HMO and PPO ACOs – it is uncertain at this time

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Save the Date

ANNUAL Conference 2019

Quality and Efficiency: How to Succeed in Risk-Based Models

April 11–13, 2019 | Manchester Grand Hyatt, San Diego, CA

THANK YOU!

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