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Introduction

An increasingly common feature of health care payment models is the transfer of financial risk from payers to providers for health care services delivered to a defined population of patients. In these “value-based payment” models, providers accept financial responsibility (i.e., liability for financial losses) should spending for most, or all, services for an attributed patient population exceed targeted levels. This financial liability is often shared with payers, and maximum risk exposure is typically capped. Even when shared, the level of risk assumption can be sizeable, potentially amounting to millions of dollars. The rationale for these payment models is that they will spark changes in the delivery system and thereby produce lower rates of cost growth and improved care access and quality. This issue brief explores options for states as they consider oversight of risk-bearing organizations (RBOs), with a focus on states that have elected to act to protect against provider insolvency.¹

Growth in provider acceptance of risk for managing population health has other potential implications, including provider financial stability. In fact, during an earlier period of provider risk-based contracting in the 1990s, multiple bankruptcies occurred among large provider organizations, especially in California where such arrangements were most common.² For this reason, states should examine the implications of providers accepting financial risk, including significant financial distress or insolvency, and the impact those consequences could have on consumers and the health care delivery system. That consideration can inform states’ decisions about whether and to what extent, they should oversee provider organizations that accept financial risk for the provision of health care services. Some states may opt to informally or formally place risk-bearing provider oversight in the hands of the health insurers with which those providers contract. Others may choose to regulate provider risk assumption directly.

Intent and Scope of State Oversight

A primary reason states may choose to intercede with RBOs is to ensure that organizations responsible for the provision of health care are financially sound. Financial protections are intended to guard against provider bankruptcies or other significant market disruptions that could threaten the delivery of care to consumers. Other reasons for state oversight of RBOs may include promoting quality health care and ensuring transparency of performance. In addition, states may identify a need to amend or adopt new regulations to assure RBOs are clear about the standards that govern their operations, since provider risk-based contracting may blur the lines between operating as a health plan and a provider. States may issue new rules or clarifying guidance that seeks to minimize confusion around what would amount to “doing the business of insurance” when it comes to accepting or transferring financial risk for the health care of a population. Following are two examples of states acting to more clearly distinguish if and when an RBO is operating as an insurer (or not).

- California is proposing new regulations that define global risk as accepting risk for professional and institutional services and requiring entities that accept any combination of professional and institutional risk to secure a license.³ Current regulations do not define what it means to accept “full” (i.e., global) risk, raising questions about when an entity needs a license.⁴
- Tennessee updated its Health Maintenance Organizations (HMO) Act to permit risk-based contracting between HMOs and providers, and to indicate that a “physician-hospital organization” is not deemed to be an insurer or HMO by accepting prepayment for health care services or entering into other risk-based payment arrangements with HMOs.^{5,6}

State Oversight Mechanisms

Currently, legal treatment and state oversight of provider organizations engaging in risk-based payment arrangements vary widely across states. State approaches and mechanisms range from allowing the market to direct RBO operations (i.e., no RBO regulation) to state licensure of an RBO as a type of health plan. Table 1 provides a range of state approaches to RBO oversight and an accompaniment to the brief, [Case Studies: State Examples of Safeguarding Financial Stability of Provider Risk-Bearing Organizations](#), describe approaches in four states: California, Massachusetts, New York and Texas.

When states have chosen to use regulation as their RBO oversight mechanism, they have often done so through insurance departments. Regulation of insurance risk typically falls within the purview of state departments of insurance, but monitoring RBOs may also involve state departments of health. A state’s department of insurance may oversee the financial parts of a risk-based contract between a payer and provider organization and the department of health may monitor other programmatic features should a state pursue a broader regulatory strategy.⁷ There may be aspects of regulation that span across both departments, and states may adopt different rules—or no rules at all—depending on the entity with which an RBO contracts (e.g., managed care organization (MCO), employer, or directly with individuals).

Table 1. State Oversight of Health Care Provider Acceptance of Financial Risk

Regulatory Mechanism	Examples
<p>No Regulation</p>	<p>Except for narrowly defined regulations of a type of RBO, Texas does not impose any regulatory requirements on RBOs.⁸</p> <p>Wyoming places no restrictions on risk-based arrangements between an HMO/insurer and a licensed provider.⁹</p>
<p>Formal Delegation to Insurers¹⁰</p>	<p>Rhode Island: The Office of the Health Insurance Commissioner (OHIC) issued regulations prohibiting an insurer from entering into a risk-based contract with an RBO unless the insurer has determined the RBO has “operational and financial capacity and resources needed to assume clinical and financial responsibility for the provision of covered services to members attributable to the provider organization.”¹¹</p> <p>Tennessee: HMOs are required to assure that the RBOs with which they contract obtain aggregate or per-patient stop-loss insurance when the RBO accepts “substantial financial risk.”¹²</p> <p>State Medicaid agencies and state employee benefit programs may also include provisions in their health plan contracts that delegate financial oversight activities of RBOs.</p>

Regulatory Mechanism	Examples
Financial Review and Approval	<p>New York: The Department of Financial Services or Department of Health (DOH) must review and approve all risk-bearing arrangements. DOH issued provider contracting guidelines outlining a tiered review and approval process for risk-based payment arrangements. The guidelines identify the department responsible for approving certain arrangements.</p> <p>Vermont: Certified accountable care organizations (ACOs) (see <i>Certification below</i>) that seek to accept downside financial risk must propose a “risk cap” and mitigation plan as part of the state’s annual ACO budget review process.¹³</p>
Registration	<p>California: RBOs that take on professional risk within the scope of their practice (e.g., for the provision of physician, ancillary, or pharmacy services) are required to register as an RBO by completing an RBO questionnaire and submitting it to the Department of Managed Health Care.¹⁴</p>
Certification	<p>Massachusetts: Risk-bearing provider organizations (RBPOs) accepting any downside risk must apply for a waiver or a risk certificate from the Division of Insurance.¹⁵ The Division of Insurance may issue a risk certificate waiver when it determines that an entity is not accepting “significant” downside risk; any risk-bearing organization that does not receive a waiver is required to obtain a full risk certificate.</p> <p>Vermont: As part of the state’s ACO certification process, applicants are required to “maintain at all times an adequate level of financial stability and solvency.”¹⁶ ACOs must assess financial vulnerabilities and report results of financial arrangements to their governing body on an ongoing basis.</p>
Licensure	<p>California: Entities that take on global financial risk for institutional (e.g., hospital) professional services (e.g., physician services) are required to obtain a license from the state.¹⁷</p>

Determination of Regulatory Application

States may develop standards against which they will evaluate an RBO’s financial position and which will trigger the required regulatory process (e.g., licensure, certification, etc.). State-defined categories, often determined by the amount of risk a provider accepts, may direct the type of financial review and safeguards an RBO must have in place, and the intensity of state oversight activities. Table 2 includes examples of the types of financial protection parameters or thresholds states may consider implementing.

Table 2. State Financial Thresholds Triggering or Exempting RBO Regulatory Review

Financial Threshold	Examples
Percent of Provider Revenue	The Division of Insurance in Massachusetts has established a guideline that organizations may file for a risk certificate waiver when an RBO applicant's risk-based payments are less than 5% of total projected net patient service revenue; risk-bearing applicants that do not receive a risk certificate waiver, are required to file for a full risk certificate. ¹⁸ Percentage of provider revenue coming from downside risk arrangements is one of multiple parameters the state considers when reviewing risk-based arrangements.
Percent of a Specific Payer's Revenue	Downside risk exposure that exceeds 15% of an RBO's Medicaid revenue may undergo more intensive review and approval in New York.
Absolute Value of RBO-borne Risk	RBOs with more than \$1 million of annual payments at risk may undergo more intensive review and approval in New York.
Amount of Specific Risk-Based Payment	Prospective capitation payments from an MCO to an RBO that are less than \$250,000 are exempt from parts of New York's RBO regulations.

In evaluating an RBO's ability to meet its financial obligations under risk-based contracts, states may require entities to submit certain financial and contractual information, including:

- Certified audited financial statements, including a balance sheet, income statement and cash flow statement, all prepared in accordance with "generally accepted accounting principles";
- Actuarial certification that risk arrangements are not expected to threaten the solvency of the RBO;
- A list of the payers with which the RBO seeks to accept downside risk and a description of the risk-based payment arrangement between insurer or payer and RBO;
- A description of the costs of health care services for which an RBO is at risk but are outside of the control of the RBO; and/or
- A description of the RBO's risk-mitigation mechanisms, including stop-loss insurance, security deposits, working capital and reserve requirements, and the organization's process for ongoing monitoring of financial risk arrangements and financial solvency.

Other Considerations

There are other factors states may wish to consider as they assess whether to regulate RBO risk assumption, and if so, how. These considerations include:

- Balancing the desire to support payer and provider contracting arrangements that test innovative and advanced accountable payment models with consumer protections;
- Assuring that the regulatory framework does not unfairly preclude some payers or providers from participating in RBO risk arrangements¹⁹;

- Balancing RBO concerns regarding the confidentiality of contract and financial information with public policy transparency objectives;
- Maximizing opportunities to educate providers on the financial and operational implications of accepting financial risk; and
- Assessing the resource requirements to successfully implement and fulfill the scope of an RBO regulation.

Conclusion

Increasing attention to payment models that transfer financial risk for health care quality and outcomes to provider organizations requires that states examine ways in which they may or may not regulate RBOs. States should analyze the risks and implications of significant financial distress or insolvency brought on by providers accepting financial risk, and the resulting danger to consumers should providers not be able to meet their obligations. If a state concludes that the risks are high, and the arrangements pose too great a threat to providers and consumers, it may want to consider leveraging contractual and/or regulatory tools to increase oversight of RBOs.

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State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's Woodrow Wilson School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies and brings together states with experts in the field. Learn more at www.shvs.org.

ABOUT BAILIT HEALTH

This brief was prepared by Erin Taylor and Michael Bailit. Bailit Health is a health care consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies and private purchasers. For more information on Bailit Health, see www.bailit-health.com.

ABOUT GEORGETOWN UNIVERSITY CENTER ON HEALTH INSURANCE REFORMS

This brief was prepared by JoAnn Volk. Georgetown University Center on Health Insurance Reforms is a nonpartisan, expert team of faculty and staff dedicated to conducting research on the complex and developing relationship between state and federal oversight of the health insurance marketplace. For more information, visit <https://chir.georgetown.edu>.

Endnotes

1. The term “risk-bearing organization” is conceptually inclusive of an Accountable Care Organization (ACO) that accepts downside financial risk, including through a shared risk payment arrangement. Many ACOs do not accept downside risk, however.
2. Dalzell MD. California Physicians Struggling—Problems Ahead for Other States? Managed Care. 1999.
3. State of California Department of Managed Health Care. California Code of Regulations, Title 28, Section 1300.49 General Licensure Requirements. Initial Statement of Reasons. <http://wpsso.dmhc.ca.gov/regulations/regs/?key=43>
4. In 2015, the California Court of Appeal, Second District, held that “the level of financial risk under a capitation agreement that causes a ‘risk bearing organization’ ... to become a ‘health care service plan’ ... is precisely the type of regulatory determination involving complex economic policy that should be made by the DMHC...” Hambrick v. Healthcare Partners Medical Group, Inc., 238 Cal.App.4th 124, 149 (2015)
5. “Physician-hospital organization” means an organization formed to allow hospitals and physicians to jointly obtain provider contracts with HMOs and other payers of health care benefits. The organization may obtain direct aggregate or excess stop-loss insurance coverage. TN Code § 56-32-102 (2017).
6. TN Code § 56-32-102 (2017)
7. States may implement separate rules, often through departments of health, to govern other aspects of RBO operations and performance, for example pertaining to RBO governance, legal status, quality improvement, care management, and protection or exemption from state and/or federal antitrust regulations or other anticompetitive requirements. The primary focus of this brief is on the regulatory options and approaches regarding the financial aspects of RBOs.
8. The Texas legislature narrowly defined a type of RBO, called health care collaboratives (HCCs) in statute to afford those entities protection from state and federal antitrust laws and rules. Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01; and “A Health Care Collaborative is an entity that undertakes to arrange for medical and health care services for insurers, health maintenance organizations, and other payors in exchange for payments in cash or in kind; that accepts and distributes payments for medical and health care services; that consists of a) physicians, b) physicians and other health care providers, c) physicians and insurers or health maintenance organizations, or d) physicians, other health care providers, and insurers or health maintenance organizations; and that is certified...to lawfully accept and distribute payments to physicians and other health care providers using the reimbursement methodologies authorized by Texas Insurance Code Chapter 848.” (Texas Insurance Code §848.001(2)).
9. McDonald, K & Rich, JP McDermott Will & Emery. Managing the Transition to Value-Based Alternative Payment Models for Healthcare Providers and Payors; Navigating State Regulations and Overcoming New Challenges. <http://media.straftfordpub.com/products/managing-the-transition-to-value-based-alternative-payment-models-for-healthcare-providers-and-payors-2017-04-12/presentation.pdf>. Published April 12, 2017. Accessed July 6, 2018.
10. State delegation to insurers to oversee providers that accept risk-based payment arrangements may be directed by statute, regulation, contract, or other instrument.
11. Rhode Island OHIC Regulation 2.
12. TN Code § 56-32-104 (2017).
13. Vermont’s approach may be explained by its historical regulatory process to review and approve hospital budgets and the fact that its one statewide ACO is projected to potentially serve more than half of the state population in the next few years.
14. A Risk Bearing Organization (RBO) 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. (California Health & Safety Code (HSC) § 1375.4 (g)(1).
15. 211 CMR 155.00 A Risk-Bearing Provider Organization is a provider organization that manages the treatment of a group of patients and bears downside risk according to the terms of an Alternative Payment Contract which utilizes methods of payment that are not solely based on fee-for-service reimbursement.
16. An Accountable Care Organization is an organization of ACO Participants (i.e., health care provider) that has a formal legal structure, is identified by a federal Taxpayer Identification Number, and agrees to be accountable for the quality, cost, and overall care of the patients assigned to it. (Vermont Rule 5.000 Oversight of Accountable Care Organizations).
17. As of the time this brief was published, California’s Department of Managed Health Care had proposed regulations entitled “General Licensure Requirements for HCSP,” which were accessed on April 26, 2018 at: <http://wpsso.dmhc.ca.gov/regulations/regs/?key=43>. The proposed regulations define a restricted health care service plan as “a person with a health care service plan license issued by the Department of Managed Health Care for the provision of, or the arranging, payment, or reimbursement for the provision of, health care services to subscribers or enrollees of another full service or specialized health care service plan under a contract or other arrangement whereby the person assumes both professional and institutional risk but does not directly market, solicit, or sell health care service plan contracts.”
18. Revenue for the provision of patient care.
19. Bacher GE, Chernew ME, Kessler DP, and Weiner, SM. Regulatory Neutrality Is Essential to Establishing A Level Playing Field for Accountable Care Organizations. Health Affairs. 2013;32(8):1426-1432. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2012.0360?url_ver=Z39.88-2003&rft_id=ori%3Arid%3Acrossref.org&rft_dat=cr_pub%3Dpubmed.