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California Case Description

California's Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene) is the legal framework through which health care entities in the state are governed. Long-standing practice of providers accepting financial risk in California—and the bankruptcies of large provider groups in the 1990s—led California's Department of Managed Health Care (DMHC) to adopt prescriptive regulations governing health plans and provider risk-bearing organizations (RBOs).¹ The state has adopted different requirements for entities based on the scope of services for which they accept financial risk and the entities with which they contract.

Licensure

Knox-Keene requires licensure by DMHC of health care service plans that accept global risk—defined as risk for both institutional and professional services—for the provision of health care services.² DMHC is also authorized to exempt entities from Knox-Keene requirements under certain circumstances.

At the time this brief was written, DMHC had proposed regulations seeking to clarify the level of financial risk that would trigger health care service plan licensure.³ The proposed regulations arose from a 2015 California Court of Appeals ruling 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 or regulatory determination...that should be made by the DMHC.” The draft regulations proposed different categories of licensure, including “full” and “restricted”.⁴ Traditional health insurance plans would be required to obtain a *full* license to operate. Entities that accept global risk as a subcontractor to a fully-licensed health plan could obtain a *restricted* license.⁵ A restricted license would exempt an entity from rules concerning marketing and enrollment.⁶ Entities that have a small market share and/or operate in well-served areas could be granted an *exemption* from California's licensure requirements as those dynamics reduce the risk of disrupting the delivery of care in the event of insolvency.

Registration

An entity in California that only takes financial risk *within the scope of its professional license* (e.g., primary care capitation) is required to register as an RBO by completing a questionnaire developed by DMHC.⁷ The questions relate to the legal status of the RBO applicant, the entities with which it contracts, and contractual payment arrangements. DMHC retains limited oversight of RBOs; most of the direct oversight is delegated to the health plans with which RBOs contract.

RBOs are required to submit quarterly and annual reports to DMHC so the department can evaluate their financial condition. DMHC has established the following minimum solvency requirements for RBOs⁸:

1. Maintain a minimum cash-to-claims ratio of 0.75.
2. Maintain positive Tangible Net Equity (TNE).⁹
3. Maintain positive working capital.
4. Reimburse, contest or deny at least 95 percent of all complete claims on a timely basis.
5. Estimate and document, on a monthly basis, its liability for Incurred But Not Reported (IBNR) claims.

The current regulation imposes solvency requirements on organizations that enter into “risk arrangements,” which are defined to include the following:

- “Risk-sharing” means, any compensation arrangement between an organization and a plan under which the organization shares the risk of financial gain or loss with the plan.
- “Risk-shifting” means, a contractual arrangement between an organization and a plan under which the plan pays the organization on a fixed, periodic, or capitated basis, and the financial risk for the cost of services provided pursuant to the contractual arrangement is assumed by the organization.

At the time this brief was written, DMHC had recently issued proposed regulations to amend the financial solvency standards of RBOs. The proposed regulations aim to clarify standards around delegated contracting arrangements and TNE and would permit an organization to identify a financial guarantor (“sponsoring agency”) to meet the financial solvency standards on behalf of an RBO. DMHC sought to adopt a definition of a “sub-delegating organization” to make sure arrangements between an entity that contracts with a health plan, but delegates risk or services to another entity that does not hold a contract with a health plan, is governed by the same solvency regulations. Sub-delegating organizations would be required to report on the risk-sharing arrangements they hold with organizations, and indicate whether they provide stop-loss insurance to their contractors, as well as the details of such insurance.

DMHC publishes on its website a list of RBOs that have completed the financial reports and whether or not they have met each of the solvency requirements; a list of RBOs that failed to comply with the financial reporting requirements is also posted on the website.¹⁰ A corrective action plan will be required of RBOs—through contracted health plan(s) or sub-delegating organizations—that fail to meet the minimum solvency standards and/or fail to comply with the reporting requirements.

As of the time this brief was prepared, California had issued 21 restricted licenses and registered 185 RBOs.

Massachusetts Case Description

The selection of five provider organizations in Massachusetts to participate in the Medicare Pioneer Accountable Care Organization Model prompted state officials to discuss a regulatory framework to protect consumers from the impact those new contractual arrangements would have, should those organizations become financially insolvent. Provider organizations in Massachusetts are diverse in size and service offerings; officials recognized the need to design an approach that could fit the various structures so as not to limit providers from evolving to more advanced payment arrangements.

Through a certification process administered by the Division of Insurance (Division), applied to all downside risk contracts, Massachusetts permits risk-bearing provider organizations (RBPOs) to accept downside financial risk in their contracts with health insurers.^{11,12} RBPOs are required to apply annually for a risk certificate from the Division. The Division has also implemented a process permitting applicants to seek a waiver from obtaining a risk certificate if they believe they are not accepting “significant” downside financial risk.¹³ The regulations do not explicitly define “significant,” and the Division has discretion to determine on a case-by-case basis if the risk is significant. It uses many decision rules to make the determination, including if the risk is greater than 5 percent of net patient service revenue. The 5 percent rule is not fixed; it is a guide the state uses in assessing the degree of risk.

Organizations seeking a risk certificate are required to obtain an independent actuary certification that the downside risk arrangements are not expected to threaten financial solvency. The Division’s decision to accept an independent actuarial certification was made in response to provider opposition to submitting sensitive financial information to the state that would allow for public release.

Many providers were concerned that disclosure of required financial information could undermine their ability to negotiate contracts with payers. The Division determined that rigorous review and certification by an independent actuary was sufficient and that the information submitted to the actuary would remain confidential.¹⁴

A request for a risk certificate waiver does not require an independent actuarial analysis. RBPOs requesting a waiver must demonstrate to the Division that the downside risk arrangement(s) does not pose a threat to the organization's financial solvency. If the Division disagrees, the RBPO will need to request a risk certificate. The state's oversight of RBPOs with risk certificates and waivers is the same. The Division will intervene if it has concerns about the financial viability of an RBPO, but otherwise leaves the monitoring to insurers or the provider organizations themselves.

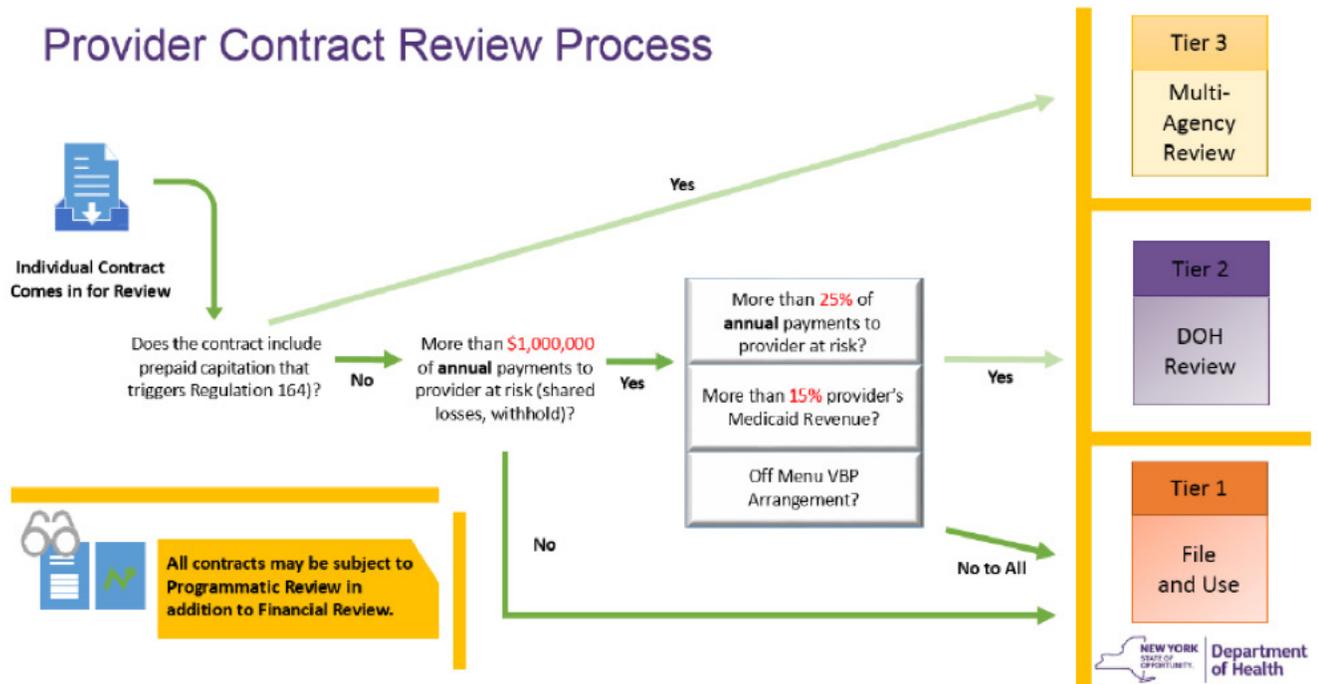
The RBPO filing application includes limited financial information which is publicly available, but information shared with the independent actuary is not. The Division posts on its website the RBPOs that have secured a risk certificate or waiver every year since the process was implemented.¹⁵ The Division also notifies three other state entities with an interest in the activities of the health care system of its determinations, including the state's Office of Medicaid (MassHealth).¹⁶ This allows health insurance carriers, payers, and other stakeholders to know which entities have undergone a financial review and been granted a risk certificate or waiver.

New York Case Description

New York Regulation 164—promulgated in 2001—establishes standards that permit insurers to transfer financial risk to health care providers or provider organizations.¹⁷ The regulation requires that provider organizations comply with certain financial and consumer protections, and the ultimate financial risk is retained by the insurer.¹⁸ In response to emerging value-based payment arrangements between insurers and provider organizations (e.g., accountable care organizations, hospital systems, and independent practice associations (IPAs)), state officials recognized the need for balancing financial solvency concerns with encouraging innovation in health care system transformation. At the same time, the state sought to clarify the type and extent of financial review that would be required of risk-sharing contracts, as financial reviews were being conducted by both the Department of Financial Services (DFS) and the Department of Health (DOH). The industry sought a more expedited review process of managed care organizations (MCO) and provider contracts, as well as clarification of what information had to be sent to which agency and when.

With feedback from a value-based payment workgroup and subcommittee on regulatory reform, DOH updated its provider contract guidelines with a focus on the amount of risk that is being accepted by a provider organization.¹⁹ The guidelines establish three tiers of regulatory review based on the annual payments at risk or a percentage of overall net worth of the organization that is in risk-sharing arrangements. The tiers define the triggers that direct a certain type of review and the supporting documentation and risk-mitigation mechanisms required under risk-based contracts. The graphic below, taken from the DOH's provider guidelines, depicts the review process and the tier payment thresholds. Note the contracts are submitted by MCOs and they can be contract templates that are implemented with multiple providers.

Provider Contract Review Process



*The New York State Value Based Payment (VBP) Roadmap defines certain payment arrangements that are consistent with its Medicaid VBP principles but allows flexibility for MCOs and providers to enter into other types of payment arrangements (i.e., “off-menu” VBP arrangements.)

Notes regarding the financial thresholds:

- The \$1 million annual payment threshold applies to the individual contract under review and only to the Medicaid managed care components of the contract.
- The 25 percent threshold applies as follows:
 - » For Medicaid contracts: More than 25 percent of the projected total annual payments made to the provider by the MCO submitting the contract across all contracts between the provider and that MCO for Medicaid managed care or Medicaid managed long-term care lines of business are at risk.
 - » For non-Medicaid contracts: More than 25 percent of the projected total annual payments made to the provider under the submitted contract are at risk.
- The 15 percent revenue threshold is met when a provider’s projected payments under the submitted contract are more than 15 percent of the provider’s projected overall Medicaid revenue from all payers.²⁰ The threshold therefore applies to all MCOs that contract with the provider and for all Medicaid contracts (including managed care and fee-for-service.)

Contracts meeting the criteria for Tier 1 undergo the least intensive review process while Tier 3 represents the most stringent review process and level of regulatory oversight. The following provides a summary of the review process for each tier.

- Tier 1: DOH performs an expedited programmatic review for contracts in this tier, and not a full financial review, though DOH requires MCOs and providers to attest to the accuracy of the contract submission including the financials. DOH reviews to make sure the submission is complete before approving. The review and approval process is typically completed within three days.

- Tier 2: DOH performs financial and programmatic reviews of these contracts. MCOs must submit to DOH evidence of a provider’s financial viability through certified audited financial statements. DOH may also require a provider to establish and provide evidence of a financial security deposit in the amount of 7.25 percent of the estimated annual medical costs for the services covered under the risk arrangement.
- Tier 3: Contracts in this tier require a review by DFS but DOH may also perform its own financial review (i.e., multi-agency review). Contracts will be reviewed for compliance with Regulation 164, which includes the following financial protection measures:
 - » Financial security deposit that is at least equivalent to 12.5 percent of the estimated annual in-network capitation revenue to be received from the insurer under the financial risk transfer agreement. Acceptable mechanism demonstrating compliance with this requirement includes a letter of credit, securities in trust, stop-loss insurance, or funds held by the insurer.
 - » Entities are exempt from the financial security deposit provisions if they hold liquid assets in amounts directed by the regulation.

In a separate but related effort, state officials have been educating providers throughout the state about value-based payment arrangements as part of the New York State Roadmap for Medicaid Payment Reform. Officials have talked with providers about what to expect when engaging in risk-sharing arrangements with plans. This has allowed the state to help providers understand the various components of risk-sharing contracts and the types of questions to ask and capabilities to have in place to be ready for risk-based contracting.

Texas Case Description

Texas does not impose regulatory requirements on risk-bearing provider organizations (RBOs) with the exception of a statutorily (and narrowly) defined type of RBO called a health care collaborative (HCC).²¹ The Texas Legislature authorized certification of HCCs in Senate Bill No. 7 to remove barriers for providers and other health care entities to partner to improve the quality and efficiency of care by securing protection from state and federal requirements governing anti-competitive behavior.²² The Department of Insurance, which administers the certification process, looks at solvency and other financial safeguards as part of the certification review and approval process, but the primary focus of the statute is antitrust barriers. Accordingly, the State Attorney General (AG) must also approve HCC certification applications for antitrust concerns. The AG’s final decision considers the quality of health care benefits and the impact on competition in the market.

HCC certification is required annually and applicants must comply with financial reserve and working capital requirements.²³ To demonstrate compliance, applicants are required to submit financial statements, including a balance sheet, income statement and cash flow statement, certified by an independent certified public accountant and prepared in accordance with generally accepted accounting principles; provide proof of insurance or other protection (or both) against insolvency; and disclose financial records of the applicant and affiliates, as requested. In addition, reserve requirements for any certified Health Maintenance Organization (HMO) or insurer that enters into a contract with an HCC must be maintained separately from and in addition to all other reserves and liabilities of the HMO or insurer and reported in the aggregate. HCC applicants are also required to provide written descriptions of the types of compensation arrangements, including risk-based payment arrangements, in their contracts.

The HCC certification process is voluntary, and only partnerships that raise anti-competitive concerns have a reason to seek certification to benefit from antitrust protections.²⁴ Other RBOs that operate in the state are not directly regulated by the state unless they take on the business of insurance, including accepting prepaid capitated payments. The state relies on a robust process of fielding inquiries and investigating concerns—including from the Texas Medical Board and Texas Medical Association—about entities operating without the appropriate license or raising concerns about anti-competitive behavior.

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ABOUT STATE HEALTH AND VALUE STRATEGIES—PRINCETON UNIVERSITY WOODROW WILSON SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS

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 Department of Managed Health Care is the primary regulator of HMOs and RBOs. The Department of Insurance regulates fee-for-service plans and most PPO plans.
2. Knox-Keene Health Care Service Plan Act of 1975 § 1345 (f) defines “Health care service plan” or “specialized health care service plan” as “either of the following: (1) Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees. (2) Any person, whether located within or outside of this state, who solicits or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.”
3. As of the time this brief was drafted, California’s Department of Managed Health Care (DMHC) had proposed regulations entitled “General Licensure Requirements for HCSP” at: <http://wpsso.dmhc.ca.gov/regulations/regs/?key=43>. Accessed May 27, 2018.
4. The proposed regulations also define a “limited health care service plan” as a “health care service plan license with waivers issued by the Department or its predecessor prior to January 1, 2000 for the provision of, or arranging, payment, or reimbursement for the provision of, health care services to subscribers or enrollees of another health care service plan under a contract or other arrangement whereby the person assumes both professional and institutional risk.
5. Restricted licensees do not contract directly with the Centers for Medicare and Medicaid Services (CMS), the California Department of Health Care Services (the Medicaid agency), employer groups, and/or individuals.
6. Proposed regulations describe a restricted health care service plan as assuming both professional and institutional risk but not directly marketing, soliciting, or selling health care service plan contracts.
7. Knox-Keene HealthCare Service Plan Act of 1975 § 1375.4 (g)(1) defines a risk-bearing organization as “a professional medical corporation or other form of corporation controlled by physicians that delivers, furnishes or otherwise arranges for or provides health care services that does all of the following: (1) contracts directly with a health plan or arranges for healthcare services for health plan enrollees; (2) receives compensation for those services on any capitated or fixed periodic basis; and (3) is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of health plans that are covered under the capitation or fixed periodic payment arrangement.” Proposed regulations clarifying the financial solvency standards for risk-bearing organizations clarify that “organization includes an entity that contracts directly with the plan or subcontracts with another organization to arrange for the health care services of a plan’s enrollees and meets the other requirements of Health and Safety Code...” See the proposed regulations for Financial Solvency of Risk Bearing Organizations here: <http://wpsso.dmhc.ca.gov/regulations/regs/?key=45>. Accessed June 6, 2018.
8. Knox-Keene Health Care Service Plan Act of 1975 § 1300.75.4.2
9. The current requirement for RBOs is positive TNE. DMHC issued proposed regulations clarifying the financial solvency standards for risk-bearing organizations. The proposed regulations establish specific parameters for satisfying the positive TNE requirements. See the proposed regulations for Financial Solvency of Risk Bearing Organizations here: <http://wpsso.dmhc.ca.gov/regulations/regs/?key=45>. Accessed June 6, 2018.
10. Risk Bearing Organizations (RBO) – Financial Report Results. California Department of Managed Health Care website. www.dmhc.ca.gov/LicensingReporting/RiskBearingOrganizations/RBO%E2%80%93FinancialReportResults.aspx Accessed May 27, 2018.
11. 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. (211 CMR 155.00: Risk Bearing Provider Organizations).
12. If an RBPO accepts downside risk in a contract with an employer, the Division of Insurance would regulate it as an insurer.
13. 211 CMR 155.00 “Downside Risk is the risk taken on by a Provider Organization as part of an Alternative Payment Contract with a Health Care Payer, Employer, or individual in which the Provider Organization is responsible for either the full or partial costs of treating a group of patients that may exceed the contracted budgeted payment arrangements.”
14. See Title 211 of the Code of Massachusetts Regulations, section 155.00 for a description of the financial information required for the risk certification and waiver processes.
15. Risk-Bearing Provider Organizations. The Commonwealth of Massachusetts website. www.mass.gov/service-details/risk-bearing-provider-organizations-0 Accessed May 19, 2018.
16. Receipt of a risk certificate or waiver is a pre-requisite to becoming a certified accountable care organization in Massachusetts. ACOs seeking certification must also attest to complying with all federal and state antitrust laws and regulations prior to becoming certified. Certification is voluntary, but ACOs seeking to contract to serve Medicaid beneficiaries must be certified. ACOs that contract with the State’s Medicaid program (MassHealth) have the opportunity to earn Delivery System Reform Incentive Payments (DSRIP).
17. 11 NYCRR 101 (Regulation 164).
18. Article 44 of the Public Health Law declares that MCOs must remain financially responsible for providing or arranging for health care services. At all times, the insurer must be able to demonstrate to the satisfaction of the state that it can fulfill its non-transferable obligation to provide coverage for health care services to subscribers in any event, including the failure, for any reason, of a financial risk transfer agreement with a provider. In considering whether an insurer has satisfied its obligation to retain full financial risk, on a prospective basis, the state shall consider the financial condition of the insurer and the health care provider, including a review of income and expenses, quality and liquidity of assets, establishment of adequate claim and other reserves, net worth, and any financial security deposit, established by the health care provider.

19. New York State Department of Health Provider Contract Guidelines for Article 44 MCOs, IPAs, and ACOs. Updated April 2017. www.health.ny.gov/health_care/managed_care/hmoipa/docs/guidelines.pdf. Accessed May 18, 2018.
20. The certification submitted and signed by the MCO requires the MCO to attest to the accuracy of the contract submission, including the provider revenue data that determines the review level.
21. A health care collaborative is an entity that undertakes to arrange for medical and health care services for insurers, health maintenance organizations, and other payers 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 also has separate regulations governing the practice and business of health insurance.
22. Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.01.
23. 28 TAC §§13.431 – 13.432
24. At the time this brief was written, Texas had received one HCC certification application.