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EXPANDING THE DMHC'S JURISDICTION OVER THE PROVIDER COMMUNITY THROUGH THE NEW GLOBAL RISK LICENSURE REGULATION

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THE APG PERSPECTIVE

Bill Barcellona

Disclaimer: Each presenter's viewpoint is the sole opinion of the presenter and is not attributable to the other parties in the presentation.

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KNOX KEENE LICENSURE

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Past State	Future State
• A full service or specialized Knox Keene license was required when: • Accepting a prepaid or periodic charge in exchange for providing or arranging for health care services • Included PREPAID premiums and capitated payments • Extended in the mid-1990's to providers accepting global capitation	• A license or exemption is now due: • When "global risk" is accepted through a prepaid or periodic charge • Which is now expanded to cover compensation at the beginning *or end of a set period* • In either a fixed amount or a percentage of savings or losses in which an entity shares

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TODAY'S FOCUS

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- What are the implications of the new general licensure rule in an era where health policy is focused on increasing the use of value-based payments to providers, including the assumption of financial and clinical risk for the outcome of their services

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CCR §1300.49 BACKGROUND ON THE REGULATION

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- Effective July 1, 2019
- "Any person who assumes global risk shall obtain a license to operate a health care service plan."

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KEY ELEMENTS OF THE RULE

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Regulation Text and Filing Form:

- Definitions that trigger licensure requirement
- Exemption from licensure under public policy rationale
- Process for licensure and exemption
- Filing form

Guidance issued on June 14, 2019:

- Process for expedited exemption filings through June 30, 2019
- Categories of arrangements subject to exemption
- Filing form
- Confidentiality form

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TWO KEY DOCUMENTS

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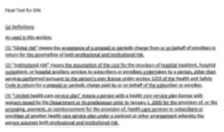
§1300.49 Regulation Text **DMHC Guidance June 14, 2019**



Final Text for DHL

(a) Definitions

As used in this section:

(1) "Global risk" means the acceptance of a prepaid or periodic charge from or on behalf of enrollees in return for the assumption of both professional and institutional risk.

(2) "Institutional risk" means the assumption of the cost for the provision of hospital inpatient, hospital outpatient, or hospital ancillary services to subscribers or enrollees undertaken by a person, other than services performed pursuant to the person's own license under section 1204 of the Health and Safety Code, in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

(3) "Limited health care service plan" means a person with 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 the 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.

DEPARTMENT OF Managed Health Care

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Guidance Regarding DMHC General Licensure Regulation
(Issued June 14, 2019)

I. Background Regarding Regulation

The Department of Managed Health Care (DMHC) recently adopted a regulation that, among other things, defines various types of risk and requires entities that assume any amount of global risk to either obtain a license under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) or receive an exemption[1] from the DMHC for the contract(s) under which the entity assumes global risk.[2]

Documents may be downloaded at: https://wpso.dmhc.ca.gov/regulations/regs/?key=43

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GLOBAL RISK DEFINED

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"Global risk" has been defined as accepting a prepaid or periodic charge from or on behalf of enrollees in return for the assumption of both professional and institutional risk.

- ***prepaid or periodic charges*** are broadly defined as "any amount of compensation, either at the start or end of a predetermined period, for assuming the risk, or arranging for others to assume the risk, of delivering or arranging for the delivery of the contracted-for health care services for subscribers or enrollees that may be fixed either in amount or percentage of savings or losses in which the entity shares."
- ***professional risk*** is financial responsibility for the cost of the provision of professional medical services, and
- ***institutional risk*** is financial responsibility for the cost of the provision of hospital inpatient, hospital outpatient, or hospital ancillary services (to the extent not provided pursuant to the person's own license)

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TREATMENT OF EXISTING AGREEMENTS

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- The Regulation only affects contracts issued, amended, or renewed on or after July 1, 2019
  - Enables existing persons or arrangements within the scope of the Regulation to apply for licensure or an exemption before their existing contract is amended or renewed.
  - Also allows limited health care service plans and restricted health care service plans licensed by the Department or its predecessor as of July 1, 2019 to continue to engage in business.
- **Amendment or renewal of the contract (including auto-renewals) will trigger the requirement for licensure or exemption**

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APPLICATION OF NEW DEFINITION

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Applies beyond traditional prepaid capitation to providers

Sweeps in newer "global" payment arrangements that cap spending above a certain limit in FFS models, and also that pay bonuses, or impose penalties

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WHO OBTAINS THE LICENSE?

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- DMHC Guidance States:
  - *Example: A hospital and a provider group set a global budget to provide care(institutional and professional) for a population of consumers. The hospital and provider group will share any savings achieved if the total expenditure for the population is less than the global budget. In this example, both the hospital and the provider group have assumed global risk and each must receive an exemption.**

When there is no single entity, all entities must apply for a license or exemption in certain shared savings arrangements

- *Guidance, at page 5

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EXPANDS DMHC JURISDICTION

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- Newer PPO and self-funded employer plan ACO models that are based on FFS provider payments, but have a capped-spending component, with bonuses/penalties
- HMO shared-savings risk pool arrangements that have not previously required licensure

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WHY DID THE DMHC ADOPT THE REGULATION?

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- Was there a crisis of financial solvency?
- Weed out "unstable" organizations
  - DMHC concerns about smaller risk-bearing entities
  - DMHC concerns about third party MCOs
- Significantly expand regulatory reach
- Significantly increase financial "backing" for risk-based arrangements
- Gather large amounts of market data to inform further regulatory and/or enforcement activity

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DMHC CONCERNS

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- DMHC is concerned about viability of smaller IPAs and third party MSOs
- Discretionary licensure and exemption process allows DMHC to force consolidation, changes in business plans and closures
  - Possible differential treatment for entities based on geographic location and market conditions
- Provides DMHC ability to control the "shape" of the marketplace in certain markets due to the "geographic factor" usage in the Regulation
- *Captain America said: "With great power comes great responsibility…"*

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COMPARISON OF NEW RBO TNE REQUIREMENTS

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RBO TNE REQUIREMENT	RKK TNE REQUIREMENT
▪ TNE shall be at least the greater of: • one percent (1%) of annualized revenues; or • four percent (4%) of annualized non-capitated medical expenses.	• $1 million; OR • the sum of two percent (2%) of the first $150 million of annualized premium revenues plus one percent (1%) of annualized premium revenues in excess of $150 million; OR • an amount equal to the sum of: ○ 8% of the first $150 million of annualized health care expenditures, PLUS ○ 4% of the annualized health care expenditures which are in excess of $150 million; PLUS ○ 4% of annualized hospital expenditures

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INTERACTION OF RBO & RKK TNE LEVELS

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- Potential duplication of TNE for organizations with both RKK and RBO entities
- Plus, the parent Plan TNE requirements, ties up a significant amount of capital in reserves
- More expensive to maintain separate RKK and RBOs and greater Admin. overhead relative to MLR

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IMPACTS ON HEALTH PLAN CONTRACTING WITH PROVIDERS – MEDICARE ADVANTAGE

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- The DMHC's jurisdiction is limited to financial solvency of MA arrangements, under CAHP v. Zingale.
- Most RKK filings are made for percentage of premium, global capitation with MA plans
- The regulation clarifies the filing process

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IMPACTS TO TRADITIONAL MEDICARE ACO MODELS

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- DMHC has determined that MSSP and Next Gen ACOs are exempt – for now...
- Newly-announced CMMI risk-model ACOs meet the definition under the regulation

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IMPACTS ON COMMERCIAL HMO

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- Impacts shared savings arrangements with involve risk pools
- Many providers renegotiated renewals out to 2-3 years – so the impact will be delayed

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IMPACTS ON COMMERCIAL PPO

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- Several PPO plans are experimenting with value-based payment models to create clinical integration of provider networks
- The cost of licensure will certainly be prohibitive for providers in this market segment

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IMPACTS ON SELF-FUNDED ARRANGEMENTS

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- The DMHC opposed APG's bill to test a global cap payment model with two self-funded payers
- They argued that it undermined the Knox Keene Act protections

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IMPACTS ON MEDI-CAL MANAGED CARE

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- There has been a trend toward greater use of global risk payments between MMC plans and restricted licensees
- This should not affect that trend
- It may effect other experiments, such as the global cap pilot by public hospitals

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IMPLICATIONS FOR ACOS

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- Accountable Care Organizations are not defined in statute and are characterized in a variety of ways
  - Narrow network HMO products
  - PPO plan networks
  - Medicare ACO arrangements
  - Self-funded health plan value-based arrangements with providers through TPAs
- They often involve several provider entities

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IMPLICATIONS FOR SHARED RISK POOLS

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- The regulation applies to upside-only risk pool payments
- What harm do such arrangements pose to the public?
- What harm do downside risk pools pose if they are not accrued to the provider?

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POSITIVE IMPACT OF GLOBAL RISK

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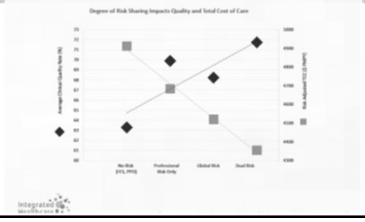
Greater Risk Sharing Associated with Higher Quality and Lower Total Cost



Existing Restricted Licensees have been financially stable and have produced lower total cost of care compared to other types of arrangements and yet have produced higher quality outcomes

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FURTHER CLARIFICATION

Guidance Document Issued June 2019

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EXPEDITED EXEMPTION PROCESS DURING PHASE-IN PERIOD

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An entity that enters into a contract involving global risk between July 1, 2019 and June 30, 2020 must submit a Request for Expedited Exemption within 30 days after the agreement is executed or after performance has begun, whichever is later

- Upon receipt of the Request for Expedited Exemption, the DMHC will issue an Order of Exemption
  - The duration of the exemption will be (i) the term of the contract, if a DMHC-licensed health plan is a party to the contract, or (ii) if a DMHC-licensed health plan is not a party to the contract, the earlier of two years from the date the exemption is granted or the renewal or amendment of the contract

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DMHC SCOPE OF REVIEW

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- The review of all filings is not limited to the question of licensure*:
  - *The receipt of an exemption from the application of the general licensure regulation does not mean the DMHC "approves" the terms of the contract for other purposes. Notwithstanding the grant of an exemption, the DMHC may find that a contract violates other portions of the Knox-Keene Act if the contract conflicts with the requirements of the Act…*
  - *Guidance, at page 1, footnote 1

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THE GUIDANCE SPECIFIES CATEGORICAL EXEMPTIONS

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- DMHC expressly excludes the following arrangements from the licensure application requirement:
  - Bundled Payment, Case Rate, Diagnosis-Related Group (DRG) Payments, and Per Diem Arrangements
  - CMS Accountable Care Organizations (ACOs)
  - Arrangements that only impact consumers covered by CDI-licensed insurers
  - DMHC footnote states that this policy may be rescinded at any time

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FINAL POINTS ON THE GUIDANCE

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- It's temporary
- DMHC is reviewing contracts to learn more about risk arrangements in order to develop further policy
- DMHC has stated that it may issue further rules in early 2020

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FILING VOLUME

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- 190+ expedited exemption requests have been received
- DMHC has granted 3 full exemptions prior to the Guidance issuance, concerning CalOptima's existing global capitation contracts with 3 restricted license plans

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ONLINE EXEMPTION LIST

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The list is posted at:
http://www.dmhc.ca.gov/Portals/0/Docs/OPL/Exemption%20Order%20Report%2010_31_2019_1.pdf?ver=2019-11-01-165428-503

Department of Managed Health Care

Orders Exempting and Waiving Global Risk Contracts Issued as of October 31, 2019

Requesting Entity	Contracting Party	Order No.	Date Issued
Humboldt Del Norte Independent Practice Association dba Humboldt IPA	Anthem Blue Cross of California	620191001	July 5, 2019
New Life Medical Group, Inc. dba Healthy New Life Medical Corporation	Blue Shield of California - Promise Health Plan (formally Care 1st Health Plan)	620191002	July 5, 2019
Regent Medical Group, Inc.	Blue Shield of California - Promise Health Plan (formally Care 1st Health Plan)	620191003	July 5, 2019
New Life Medical Group, Inc. dba Healthy New Life Medical Corporation	Blue Shield of California - Promise Health Plan (formally Care 1st Health Plan)	620191004	July 5, 2019
Regent Medical Group, Inc.	Central Health Plan of California, a California corporation	620191005	July 5, 2019

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PARENT PLAN FILING REQUIREMENTS

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- Plans must continue to file their provider contracts*
  - *Neither the regulation nor this guidance relieves DMHC-license health plans from the obligation to file their contracts with the DMHC for review and approval as required by the Knox-Keene Act and its implementing regulations, including California Code of Regulations, title 28, section 1300.51.*
  - *Guidance, page 2, footnote 3

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THE FORMAL EXEMPTION PROCESS

Based on the Regulation Text

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THE FORMAL EXEMPTION PROCESS

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- Persons that wish to be excluded from the license application process may apply to the Department for an exemption
- The Department is required to grant an exemption upon review and a finding that the action is in the public interest and not detrimental to subscribers, enrollees or other persons regulated under the Knox-Keene Act
  - The Department has 30 days from receipt of a request for an exemption to issue a decision

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REQUESTS FOR EXEMPTION

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- Requests for exemption must include:
  - financial statements related to the applicant's viability;
  - the total percentage of annualized income of institutional risk the applicant will assume;
  - the contract(s) for the assumption of risk;
  - the estimated number of subscribers and enrollees;
  - the geographic service area under consideration; and
  - any other information the applicant believes to be appropriate or relevant for the Department to consider.

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FACTORS CONSIDERED BY DEPARTMENT

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- The DMHC will consider the following factors when weighing a request for exemption:
  - the person's portion of contracted global risk when compared to the person's overall business;
  - *the portion of market share* the person assumes for global risk in the geographical region compared to the market share assumed by other persons within the region, and *whether disruption will occur in the marketplace if the person fails to maintain financial solvency*;
  - the *financial capacity to assume a portion of global risk* without jeopardizing enrollee access to basic health care services in the geographical region;

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FACTORS CONSIDERED BY DEPARTMENT

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- the *potential impact on the health care marketplace* in the geographical region in which the person operates, including the impact on contracted institutional and professional providers, if the person is unable to maintain financial solvency; and
- whether the issuance of an exemption will negatively impact public interest or protection of the public, subscribers, enrollees, or persons subject to the Knox-Keene Act, if the person assumes global risk.

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EXEMPTION DETERMINATION STANDARDS ARE BROAD

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Could there be a challenge to the DMHC factors as being vague?:

- the person's portion of contracted global risk when compared to the person's overall business;
- *the portion of market share* the person assumes for global risk in the geographical region compared to the market share assumed by other persons within the region, and *whether disruption will occur in the marketplace if the person fails to maintain financial solvency*;
- the *financial capacity to assume a portion of global risk* without jeopardizing enrollee access to basic health care services in the geographical region;
- the *potential impact on the health care marketplace* in the geographical region in which the person operates, including the impact on contracted institutional and professional providers, if the person is unable to maintain financial solvency

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MANY UNANSWERED QUESTIONS

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- Does the regulation have a chilling effect on further transition to value-based payments between payers and providers?
- The impacts include:
  - High cost of filing and administrative compliance for relatively low-risk ventures ($1 million to file + annual assessments, etc.)
  - Ambiguity and uncertainly of application of the rule
- Will it drive further provider consolidation in the market?

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THE CAHP PERSPECTIVE

Christina Wu

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DELEGATION OVERSIGHT

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- Health plans are required to file all contracts that delegate health plan responsibilities with the DMHC.
  - Examples: Contracts with providers, facilities, or pharmacy benefits managers (PBMs).
- Health plans are responsible for overseeing all delegated entities.

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RISK BEARING ORGANIZATIONS

- What is an RBO?
- Recent DMHC Rulemaking - Updated RBO Financial Solvency requirements:
  Cash-to-claims ratio, tangible net equity, use of sponsoring organization to meet tangible net equity, and RBO financial filing requirements.

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THE CHA PERSPECTIVE

Amber Kemp

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DMHC GENERAL LICENSURE REGULATION

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BACKGROUND

DMHC licensing provides important protections for consumers, including ensuring:

- The adequacy of health care provider "networks" — the hospitals, doctors, and other services covered by a health plan
- The financial solvency of health plans that pay for consumers' health care costs

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DMHC GENERAL LICENSURE REGULATION

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BACKGROUND

DMHC oversight is unnecessary when health care providers enter into arrangements that:

- Take on modest amounts of risk
- Manage the risk they have taken on
- Have a proven track record of sharing risk with payers in a financially stable manner
- Participate in payment arrangements allowed by law, and under careful regulation by the Medicare or Medi-Cal programs

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DMHC GENERAL LICENSURE REGULATION

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ISSUE

- DMHC's general licensure regulation expands DMHC's power over the health care marketplace and threatens to disrupt innovative health care delivery that benefits all Californians.
- Many health care providers that have adopted innovative, yet low-risk, payment models have been unnecessarily swept into licensing.
  - This includes bundled payments, institutional risk pools, and accountable care organizations – common tools for improving the quality and coordination of care while posing minimal or no risk to patients, payers, and providers.
  - These safe, common arrangements should be presumptively exempt from licensing.
- Health care providers must have the flexibility to utilize low-risk payment arrangements that result in lower health care costs for consumers.

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DMHC GENERAL LICENSURE REGULATION

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DMHC Licensure Exemption (SB 714)

- Sponsored bill to clarify the process to receive an exemption from the Department of Managed Health Care's Knox-Keene licensure regulation and presumptively exempt particularly low-risk payment arrangements.
- Legislation successful in getting stakeholders and the Department to discuss issue, work on solution.

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THANK YOU!

Questions?

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