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CLIENT ALERT

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# The DMHC's Final Guidance on the General Licensure Regulation ("Restricted Health Plans") The Lull Before the Storm

On Friday, June 14, 2019 the Department of Managed Health Care (the "Department") issued All Plan Letter 19-014 (OLS) ("APL") containing its formal guidance regarding implementation of the General Licensure Requirements (for global risk contracting), 28 C.C.R. Section 1300.49 (the "Rule") (See discussion below). The APL modifies an earlier draft guidance circulated among stakeholders on May 3, 2019 and seeks to clarify certain filing and other issues associated with the Rule.

The APL eases the immediate pain anticipated by each "Entity" subject to the Rule by providing for a one-year "phase-in" period for the Rule's implementation, for contracts executed, renewed or amended from July 1, 2019 through June 30, 2020. During that period, any Entity that submits its global risk contracts along with a Request for Expedited Exemption to the Department within thirty days after executing or renewing the contracts will be granted an automatic exemption from the Rule. The exemption period will be for the term of the contract if a licensed health plan is a party to the contract; otherwise, the exemption will be granted for the earlier of two years from the exemption date or the contract renewal or amendment date.[1]

The APL defines the "Entity" that is subject to the Rule, as a person or organization that (i) is not licensed under the Knox Keene Health Care Service Plan Act of 1975 ("Knox-Keene Act") or as an insurer by the California Department of Insurance, and (ii) "assumes *any* amount of global risk on a pre-paid or periodic basic, including by providing a payment at the end of a contract or term" (emphasis added).

Through the Rule and the APL, the Department has taken a broad view of what constitutes global risk and the number of business arrangements that may require Knox-Keene Act licensure. Under the usual understanding of "global risk," an Entity takes on the financial responsibility related to the costs of professional services AND institutional care (i.e., hospital care). If costs in either category increase for whatever reason, the Entity may lose money. If costs decrease in either category for whatever reason, the Entity may make money. Thus, the Entity is incentivized to manage care as cost efficiently as possible.

[1] In footnote 1 of the APL, the Department notes that the Department's granting of an exemption does not equate to approval of the contract for other purposes. The Department could determine that other contract provisions conflict with and therefore violate other Knox-Keene Act requirements.

Through an unusually expansive definition of "prepaid or periodic charge," the Department has greatly expanded the historic understanding of "risk" to include the possible failure of a provider of one category of services (professional/institutional) to participate in a gain from the provider of the other category of services (institutional/professional). For example, a medical group entering into an agreement to merely share in a hospital cost-savings program is now to be considered as assuming global risk (i.e., the medical group is apparently taking the "risk" that it might not realize a gain from sharing in hospital cost-savings because the hospital, in fact, did not save any costs). Similarly, a medical group participating in a risk arrangement where excess hospital costs in one year are carried over to reduce any hospital cost-savings bonuses in subsequent years is also to be considered as assuming global risk regardless of whether such losses are ever required to be repaid in subsequent years (i.e., it is difficult to translate the Department's concerns, but the Department appears to be concerned that the medical group is taking the risk that future bonuses might not be realized because of excess hospital costs in prior years even though such medical group is not responsible for ever paying such excess costs out of its own pockets).

**WHAT THE RULE SAYS**

Under the Rule, a person who accepts global risk "shall" obtain a license to operate a health care service plan. However, a person accepting global risk can apply for an exemption, which the Director will grant after finding that the exemption is "in the public interest and not detrimental to the protection of subscribers, enrollees or persons regulated under the Knox-Keene Act."

A person accepts global risk when the person assumes both professional and institutional risk in exchange for a prepaid or periodic charge from or on behalf of enrollees. The assumption of risk is categorized as "Professional Risk" where physicians and other licensed or certified providers assume the cost for providing physician, ancillary or pharmacy services for subscribers or enrollees; "Institutional Risk" refers to the assumption of the cost for providing hospital inpatient, hospital outpatient, or hospital ancillary services for subscribers or enrollees, other than services performed under the person's own license under section 1253 of the Health and Safety Code.[2]

The Rule anticipates that Entities accepting global risk shall not apply for a full Knox-Keene license, but will apply for a restricted Knox-Keene license ("RKK License"). The RKK License permits an Entity to enter into global risk arrangements with fully licensed health plans on a contract-by-contract basis. The RKK licensee cannot market its own products, however.

The RKK License applicant will need to file all exhibits required of a fully licensed plan and specify therein the function that each of the RKK License applicant or the health care plan with which it will contract will be responsible. There is a "Restricted Health Care Service Plan Responsibility Statement" that the applicant and fully licensed health plan both need to sign as to their respective

[2] Section 1253 concerns health facilities and states:

(a) No person, firm, partnership, association, corporation, or political subdivision of the state, or other governmental agency within the state shall operate, establish, manage, conduct, or maintain a health facility in this state, without first obtaining a license therefor as provided in this chapter, nor provide, after July 1, 1974, special services without approval of the state department. However, any health facility offering any special service on the effective date of this section shall be approved by the state department to continue those services until the state department evaluates the quality of those services and takes permitted action.

(b) This section shall not apply to a receiver appointed by the court to temporarily operate a long-term health care facility pursuant to Article 8 (commencing with Section 1325).

contractual responsibilities and compliance with the Knox-Keene Act.

To apply for an exemption to the RKK licensing process, an applicant must file certain financial exhibits and information showing:

- The total percentage of annualized income of institutional risk the person will assume and how it will be assumed;
- The contract for the assumption of global risk;
- The estimated number of subscribers and enrollees for whom the person will provide health care services;
- The geographic service area under the global risk arrangement in which the person intends to operation; and
- Any other information the person believes is appropriate or relevant for the Director to consider when reviewing the exemption request.

The Director will then review the submitted information and consider five factors related to the applicant's financial capacities, the amount of global risk compared to its overall business, and the effects on enrollees and the marketplace should the applicant fail to maintain financial solvency and public interest considerations. Specifically, these include:

- 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: and,
- The issuance of an exemption will not 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.

There is no requirement that the exemption applicant produce a market impact study and yet, the Department is considering that factor in making its determination as to the exemption. It is therefore unclear whether the Department will have the resources to undertake that analysis with economic analysts or whether the substantial costs of such a study will have to be borne by the applicant.

The Director has thirty (30) days after receiving the exemption request to issue its decision.

**WHAT APL 19-014 EXPLAINS**

Arrangements That Do Not Require Filing. The Department has excluded certain financial arrangements from the filing requirements "at this time." Those include the following arrangements:

- Bundled payments[3]
- Case rates
- DRG payments
- Professional services contracts for hospital emergency department services
- Per diem payments where the assumption of financial responsibility is for episodes of care, including hospital and professional services and other medical services associated with the episode

[3] Footnote 4 of the APL notes: If an arrangement/contract involves a combination of (i) bundled payments, case rates, DRG payments and/or per diems, plus (ii) other types of global risk sharing, such as risk pools or global budgets, the Entity assuming global risk must apply for an exemption.

- Agreements between a licensed health plan and a provider for professional capitation only where the provider assumes financial responsibility for professional services that may be provided in a hospital facility under the parties' Division of Financial Responsibility.
- CMS Accountable Care Organizations that are not Knox-Keene Act licensed health plans such as medical groups and hospitals.
- The assumption of global risk where all consumers impacted by the global risk arrangements are covered by a California Department of Insurance licensed insurer.

Phase-in Period for Automatic Exemptions. As discussed above, the Department has established a "phase-in" period for all contracts that include global risk, which the Entity executes or renews[4] between July 1, 2019 and June 30, 2020.[5] Under the phase-in period, any Entity that assumes global risk, or a party acting on the Entity's behalf, must file its contracts along with a Request for Expedited Exemption to the Department thirty days after executing or renewing the contract within the phase-in period.

The Department will automatically grant an exemption to those contracts for the term of the contract if a licensed health plan is a party to the contract; otherwise, the exemption will be granted for the earlier of two years from the exemption date or the contract renewal or amendment date.

Confidentiality. Entities filing their global risk contracts can request confidentiality for all or part of the contract by submitting a justification for the confidentiality request and the period for which confidentiality is requested. Unlike other exhibits where confidentiality is automatically granted with no time limitation (i.e., provider rates), the Department has not provided for automatic confidentiality for the rates, including the global risk arrangements contained in the contracts. If the Department does not grant confidentiality for those rates *ad infinitum*, then an Entity that does not want disclosure of the rates after the confidentiality period granted ends, will be forced to apply again to prevent public disclosure.

**IMPACT OF THE RULE AND FUTURE FILINGS**

Entities can be relieved that the phase-in period gives them at least one year in which to determine whether the initial and ongoing costs of obtaining an RKK License are worthwhile, whether it is in their best interests to abandon their global risk arrangements, or whether they can successfully advocate for an exemption from the Department. A big unknown is how the Department will apply the exemption criteria after the one-year phase-in period. Lest we forgot, in its final Statement of Reasons in the rulemaking, the Department anticipated that two thirds of the estimated 67 ACOs in California will be subject to the Rule and its licensure requirements.

Although the goals to protect enrollees and ensure financial stability in the marketplace are laudatory, it is unclear how this regulation advances those goals. The Department did not cite any evidence of a financial failure by the Entities they desire to regulate for the protection of consumers. Rather, the Department may be trying to obtain a greater role in the managed care contracting process without an articulated focus on the ill it is trying to cure.

The Department, for example, has never taken the position that it has the authority to regulate a provider who merely contracts for its own services (i.e., a medical group contracting for professional

[4] A substantive amendment concerning the global risk arrangement will also trigger the filing requirement.

[5] An evergreen renewal is considered a renewal under the APL and the renewed contract must be submitted within thirty days of the contract renewal date.

services, a hospital contracting for institutional services); and the Department's concern for the financial stability of providers does not extend to reviewing or regulating the rates that a provider will accept from a payor. Now, however, the Department has taken the peculiar position that it must ensure the financial stability of providers that contract for their own services and want to share in any cost savings generated by other providers. That is, such providers are assuming the risk that if no cost savings are generated, they will make the exact same amount of money as they would make if they had not agreed to share in any costs savings at all. To date, the Department has not explained how a provider with a base rate of $X plus an opportunity to earn a bonus of $Y is worse off than a provider with a base rate of $X and no opportunity to earn a bonus of $Y.

Given these unknowns and the Department's broad interpretations to date, providers who participate in risk pools and other shared savings models, may want to contact the Department early on to (hopefully) gain insight into how the Department will apply the criteria to their circumstances.

How this will play out in the marketplace is unclear. More entities may seize the opportunity to get better reimbursement through the RKK license. Alternatively, innovative risk sharing approaches catalyzed by health care reform may be stymied and ultimately abandoned due to the costs of RKK licensure and the ongoing regulatory costs associated with licensure. Such a result would be contrary to reports by the U.C. Berkeley School of Public Health, which recommend that California provide incentives for more integrated, risk-based delivery models to decrease the cost of care and increase the quality of care delivered.

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