COPE HEALTH SOLUTIONS

The Who, Where, Why and What You Should Do Next with the California DMHC's Expanded Licensing and Exemption Requirements

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Effective July 1, 2019, the California Department of Managed Health Care ("Department" or "DMHC") is requiring organizations under certain conditions to file their risk contracts with DMHC.[1] California managed care organizations, medical groups, risk bearing organizations (RBOs), clinically integrated networks (CINs) and any entities looking to enter into upside or downside financial risk agreements will need to understand who needs to file (and who does not), what to file and when to file. Also important is the consideration of the longer-term strategy to address new opportunities and potential pitfalls amid increased oversight.

This article provides guidance on the above and consideration on where this action may be headed and the next steps and strategies providers should consider, such as the leveraging or alignment with a Restricted Knox-Keene (RKK) health plan to mitigate future risks. We will also discuss the Department's new regulation imposing reporting SB260[2] requirements on RBOs.[3]

Introduction

A number of California health systems, physician groups, hospitals, RKKs and RBOs have registered questions and concerns regarding the expanded DMHC licensure requirements for risk contracts. Health care organizations operating in California and entering into alternative payment models need to prioritize understanding the implications of the new licensing regulation and develop a strategy for compliance. One of the goals of the licensure regulation appears to be to expand the definition of global risk to include shared savings models. The purpose of the shared savings model inclusion may be to regulate such advanced direct payment models in the self-funded employer plan market.

The sweeping language of the regulation is circumscribed by its June 14, 2019 "*All Plan Letter*"[4] (APL). To minimize adverse impacts on both the industry and Department staff, the DMHC has prioritized the contracts required to be filed as "Expedited Exemptions" and will grant these contracts approximately two years of protection from licensure requirements.

The APL exempts certain risk contracts and relationships from licensure *at this time* and provides for a filing process to gain short-term protections, also termed "exemption." During the phase-in period, the DMHC will automatically grant an exemption to contracts submitted to the DMHC. 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.

The phase-in period is July 1, 2019, to June 30, 2020. During the phase-in period, entities that assume global risk must file with the DMHC their global risk contracts within 30 days of execution of the contract by all parties. It is important to note that exemption from the DMHC does not need to be received prior to finalizing or beginning performance under the contract.

Sub-capitated RBOs and their contracting partners must also understand new SB260 reporting and solvency requirements. The RBO SB260 reporting requirements will capture smaller RBOs previously not subjected to such requirements and subject them to routine solvency and timely claims payment reporting. The assumed objective is to ensure all delegated RBOs have capable infrastructure to manage increasingly complex capitation contracts, provide high-quality care and access to specialists and pay the claims of contracted providers.

Longer Term Strategy is Essential

The significant takeaway is that the licensing emphasis combined with the RBO regulation, as applicable, should be prompting larger conversations around a three to five year strategy:

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- Hospitals and health systems must both continue to engage in value-based payment arrangements and take premium risk and also grow their volume and capabilities in order to remain relevant in the California managed care industry. Health systems with restricted Knox-Keene (RKK) licenses now have a greater reason to consider bringing all provider contracting arrangements under this umbrella. This includes clinically integrated networks (CINs), as most incorporate some sort of "risk" arrangement, even if only for upside.

  Health systems should take this unique opportunity to revisit their overall managed care and population health strategy. This includes gaining an understanding not only of the new regulatory requirements and their impacts, but also:

  - Data analytics including compliant physician performance benchmarking and data sharing
  - Quality improvement opportunities including but beyond typical Healthcare Effectiveness Data and Information Set (HEDIS) and Star gap closure
  - Financial pro forma development that includes the net contribution margin to the system from all risk contracts and the impact to subsidies such as DSH, provider fee and 340b discounts
  - Network adequacy requirements and optimization opportunities to improve performance
  - Health plan and provider contract structure
  - Enhanced care model design and implementation

- Hospitals not part of a larger system but which are either engaged in or considering ambulatory network development and/or dual risk type arrangements may also be impacted. These hospitals need to consider potential impacts and options including consideration of developing an RKK, or becoming a part of one, to provide a foundation for broader risk contracting.

- Medical Groups, IPAs and commercial ACOs will need to either stop participating in institutional risk pool arrangements or also consider running all contracts through an RKK and subjecting themselves to full jurisdiction of the Department.

- Small IPAs (RBOs) and commercial ACOs with less than 5,000 to 10,000 lives will most likely find the burdens of compliance and the requirement of $1 million in tangible net equity (TNE) too onerous. These groups will need to align with larger, more capable provider groups and health systems or sell to larger IPAs, a Restricted Knox Keene, health systems or health plans. To be clear, administrative costs are likely too high and adverse risk may be too much a factor for any RBO, including now commercial ACOs, with less than roughly 30,000 lives, irrespective of line of business, to deliver sustainable quality and value. It will be "Let's Make a Deal" time in California.

Who Must File, When and What?

Determining who must file is complex and confusing. However, the determination is less of a legal analysis and primarily involves a complex analysis of relationships and exemptions.

Here are a few of the questions medical groups, RBOs, IPAs, commercial ACOs, hospitals and health systems should keep in mind:

- Is the entity exempt from filing because it is in a CMS ACO contract or an arrangement with a CA Department of Insurance (CDI) insurer?

- Is the entity assuming any amount of "global risk" beyond the professional or institutional license on a prepaid or periodic basis, including any kind of back-end payment or reward?
  - If so, is it a category of contract that is not required to be filed for at this time? (Bundled payment, Per Diem, Case Rate, Professional services contracts provided in hospital facilities with no shared savings from reduced utilization)
- Is the contract new or will it be renewed (without "substantive" changes) between July 1, 2019 and June 30, 2020? (This will affect most contracting

parties that did not scramble in June to re-contract.)
- Which party must file? In dual risk arrangements, it appears that parties must file separately if they both receive funds from the risk pool.
- How best to organize and simplify information on, for instance, typical dual risk arrangements that may fill a large 6-inch binder in order to make it easier for regulators to review and opine on?
- Does the exemption from licensing requirements take effect upon filing and how long does it last, depending on whether it is a contract with a DMHC licensed plan or not?

Sorting through this maze, here are the known and possible impacted parties:

- Providers with commercial ACO contracts
- Health systems with clinically integrated networks and / or capitation contract arrangements with physicians
- Physician groups, commercial ACOs and IPAs with delegated agreements from licensed DMHC health plans for any risk that falls outside Professional Services (Hospital risk share or gainsharing)

By defining "global risk" very broadly, while providing extended but temporary exemptions, the Department is providing a sentinel warning regarding what will be required in order to take risk outside the lanes of the provider's direct competencies. This will funnel more risk arrangements into licensed entities subject to greater regulatory requirements. Ideally, the Department will create a database of IPA risk contracts and metrics, (although filing entities will not submit through an e-filing system, and how they will be tracked is unclear).

Taken together with increased expectations regarding health plan compliance monitoring of providers taking or managing risk, including RBOs and MSOs, and the new financial filing requirements for RBOs, the Department expects that it can better police the entire industry. However, the added cost and administrative burdens of participating in advanced payment models that incorporate risk arrangements will most certainly increase health care costs.

Endnotes

[1] https://wpso.dmhc.ca.gov/regulations/regs/?key=45

[2] A risk bearing organization (RBO) is either 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 of the Health and Safety Code, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services. An RBO does not include an individual or a health care service plan. An RBO contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees; receives compensation for those services on any capitated or fixed periodic payment basis; and is responsible for the processing and payment of claims made by providers for services.

[3] https://wpso.dmhc.ca.gov/regulations/docs/regs/45/1553276086155.pdf

[4] http://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL%2019-014%20(OLS)%20%20Guidance%20Regarding%20General%20Licensure%20Regulation%20(6_14_19).pdf?ver=2019-06-14-145848-620

For more information on how the California DMHC's Expanded Licensing and Exemption Requirements impact your organization, please contact Allen Miller or Cindy Ehnes at amiller@copehealthsolutions.com, cehnes@copehealthsolutions.com, or 213-259-0245.