Overview of Risk-Sharing Arrangements

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A. Introduction

During the 1999 California legislative session a series of health care reforms and initiatives were signed into law. SB 260 (Speier - 1999) [Health care coverage: risk-bearing organizations: financial solvency] charged the Department of Managed Health Care with the responsibility of reviewing the financial solvency of certain medical providers that accept financial risk for the delivery of health care services for individuals participating in managed health care programs. Health & Safety Code § 1375.4.

SB 260 (Speier - 1999) also created the Financial Solvency Standards Board to advise the Director on matters of financial solvency affecting the delivery of health care services. (Health & Safety Code § 1347.15(b)(1).) One of the specific charges given the Board was to study and report to the Director regarding "The appropriateness of different risk-bearing arrangements between health plans and risk-bearing organizations." Health & Safety Code § 1375.4(d)(2). Risk arrangements, which have been informally referred to as incentive arrangements, include both risk-sharing arrangements and risk-shifting arrangements.[1]

While the Board has engaged in on-going discussions regarding risk arrangements, the purpose of this background paper is to facilitate a more focused discussion regarding some common forms of risk arrangements and certain regulatory policy issues they raise. Following this introduction, this document is structured as follows:

- Summary of Knox-Keene Provisions Related to Risk Arrangements
- Descriptions of Basic Risk Arrangement Structures
- The Financial Impact of Risk-Sharing Arrangements on Risk-Bearing Organizations

[1] A "risk-sharing arrangement" is defined as any compensation arrangement between an organization and a plan under which both the organization and the plan share a risk of the potential for financial loss or gain in excess of five percent (5%) of the organization's annual capitation revenue. (Rule 1300.75.4(d)(1).) A "risk-shifting arrangement" is defined as 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 arrangement is assumed by the organization. Rule 1300.75.4(d)(2).

- Historic Regulatory Handling of Risk Arrangements
- Suggested Discussion Points for Board Discussions
- Exhibit 1 - Sample Contract, Division of Financial Responsibility (Blue Cross)
- Exhibit 2 – Sample Contract, Division of Financial Responsibility (Blue Shield)
- Exhibit 3 – Regulation 1300.67. Scope of Basic Health Care Services

B. Summary of Knox-Keene Act Provisions Related to Risk Arrangements

Although it is unlawful for any person to engage in the business of a health plan or to undertake to arrange for the provision of health care services in return for prepaid or periodic consideration without first securing a Knox-Keene license, Health & Safety Code § 1349, health care providers[2] *operating within the scope of their license* are impliedly exempt from this requirement. Based on this implied exemption, health plans contract with a variety of health care providers on a prepaid or periodic basis who then become responsible for furnishing actual health care services to health plan enrollees. Notwithstanding that the responsibility for the delivery of health care services can be delegated to licensed health care providers, a health plan remains charged with the responsibility of maintaining "the financial viability of its arrangements for the provision of health care services." (Health & Safety Code § 1375.4 (a)(1).) If a plan maintains capitation or risk-sharing contracts, it must ensure that each contracting provider has the administrative and financial capacity to meet its contractual obligations. Rule 1300.70(b)(2)(H)(1).

Arguably, the most fundamental tenant of the Knox-Keene Act is that health plans must ensure: (1) that all basic health care services are readily available at reasonable times to all enrollees (Health & Safety Code § 1367(e)); and (2) that these services are furnished "in a manner providing for continuity of care and ready referral of patients to other providers consistent with good professional practice." Health & Safety Code § 1367(d).

To accomplish this mandate, a health plan must maintain the "organizational and administrative capacity to provide services to subscribers and enrollees." (Health & Safety Code § 1367(g).) A

[2] "Provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services. Health & Safety Code § 1345(i).

health plan must also demonstrate to the Director that it maintains a fiscally sound operation and adequate provision against the risk of insolvency. (Health & Safety Code § 1375.1(a)(1).) In determining whether a health plan's operation is fiscally sound, the Director must consider the financial soundness of the plan's arrangements for health care services, the schedule of rates and charges used by the plan, and its agreements with providers for the provision of health care services. Health & Safety Code § 1375.1(b)(1) and (3).

The bulk of health plan delegation involves contracting with risk-bearing organizations. A risk-bearing organization is defined 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. Health & Safety Code § 1375.4 (g)(1).

As part of the plan's responsibility to ensure the uninterrupted delivery of health care services, the Knox-Keene Act dictates that all contracts with providers must "be fair, reasonable, and consistent with the objectives of this chapter."[3] (Health & Safety Code § 1367(h)(1).) Accordingly, contracts between health plans and providers may not contain any incentive plan that includes specific payment made directly, in any type or form to a physician group as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services provided to a specific enrollee or groups of enrollees with similar medical conditions. (Health & Safety Code § 1348.6(a).) While this restriction does not "prohibit contracts that contain incentive plans that involve general payments, such as capitation payments, or shared-risk arrangements that are not tied to specific medical decisions involving specific enrollees or groups of enrollees with similar medical conditions," (Health & Safety Code § 1348.6(b)), health plans must "be able to

[3] The "fair and reasonable" language contained in this provision does not authorize the Director "*to establish the rates charged subscribers and enrollees* for contractual health care services," (Health & Safety Code § 1367(j)).

demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management." Health & Safety Code § 1367(g).

To enable risk-bearing organizations to be informed regarding the financial risk assumed under their contracts, detailed health plan disclosures are mandated.[4] Additionally, current law mandates that for all risk-sharing arrangements, plans must provide the organization with a preliminary payment report, no later than 150 days and payment no later than 180 days after the close of the organization's contract year, or the contract termination date, whichever occurs first. Rule 1300.75.4.1(a)(6).

Because economic incentives inherent in risk arrangements have the potential to influence medical decisions, health plans are required to disclosure in their Evidence of Coverage a statement clearly describing the basic method of reimbursement, including the scope and general methods of payment made to its contracting providers of health care services, and whether financial bonuses or any other incentives are used. (Health & Safety Code § 1367.10(a).) Upon request, health plans and providers are required to provide a detailed written summary describing any bonus or incentive arrangements. Health & Safety Code § 1367.10(b).

C. Basic Risk Arrangement Structures.

The primary forms of risk arrangements include capitation, risk pools, withholds and stop-loss arrangements. Capitation is a set amount of money received by or paid to a provider on a per member per month basis rather than on the level of health care services provided. Risk arrangements usually fall within one of three basic structures: full risk, shared risk or global risk arrangements.

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[4] Health plans must disclose: (A) a matrix of responsibility for medical expenses (physician, institutional, ancillary, and pharmacy) which will be allocated to the organization, facility, or the plan under the risk arrangement; (B) expected/projected utilization rates and unit costs for each major expense service group (inpatient, outpatient, primary care physician, specialist, pharmacy, home health, durable medical equipment (DME), ambulance and other), the source of the data and the actuarial methods employed in determining the utilization rates and unit costs by benefit plan type for the type of risk arrangement. (Rule 1300.75.4.1 (a)(4)(A) &(B).) In addition, all factors used to adjust payments or risk-sharing targets, including but not limited to the following: age, sex, localized geographic area, family size, experience rated, and benefit plan design, including co-payment/deductible levels. (Rule 1300.75.4.1(a)(4)(C).) On a quarterly basis, plans must provide a detailed description of each and every amount (including expenses and income) that is sufficient to allow verification of the amounts allocated to the organization and to the plan under each and every risk-sharing arrangement. Rule 1300.75.4.1(a)(5).

Full risk ("dual risk") contracting is often used to describe the situation where a health plan enters into multiple capitation agreements to shift the majority of the risk for the provisions of health care services to providers. Typically, a health plan will capitate a hospital to provide, arrange and pay for institutional risk, which typically includes a combination of hospital, skilled nursing and hospice care. The health plan also capitates a physician network that is closely associated with the hospital to provide, arrange and pay for professional risk, which typically includes physician and ancillary provider services. Either or both of these capitation arrangements may include additional risk arrangements for home health care, ambulance, durable medical equipment, corrective appliances, pharmacy, and injectibles.

Shared risk contracting is often used to describe the situation where a health plan enters into a capitation agreement with a physician organization to render professional services, but does not enter into a capitation arrangement with a hospital. In these situation the health plan "retains" the institutional risk, but requires the provider organizations to participate in a one or more risk arrangements relating to the provision of institutional services. The provider organization may also enter into additional risk pools for out patient hospital services, skilled nursing, hospice, home health care, physical therapy, ambulance, durable medical equipment, corrective appliances, pharmacy, and injectibles.

Global risk contracting is often used to describe the situation where a health plan enters into a capitation agreement with only one health care provider to shift the entire risk for the provision of both institutional and professional health care services to a single entity. These arrangements include most ancillary services - skilled nursing, hospice, home health care, ambulance, durable medical equipment, corrective appliances, pharmacy, and injectibles. This type of contracting is limited to organizations that have secured a Knox-Keene license or a Knox-Keene license with waivers.[5]

Regardless of the structure, capitation arrangements are often supplemented with risk pools, withholds and stop loss coverage. Withhold arrangements are generally funded through capitation

[5] No health care service plan licenses with waivers or "limited licenses" have been issued since January 1, 2000. Health & Safety Code § 1349.3.

deductions. In effect, withholds are delayed payments conditioned upon performance. Withhold funds are used to reimburse a variety of health care services such as specialty referrals, pharmacy/injectibles, inpatient hospital services (which can either be administered by the health plan or the contracting hospital), ancillary services, physical therapy, quality incentive and bonus programs and/or unanticipated health care costs. Risk pool arrangements operate similar to withholds but are funded through a preset allocation (or set aside) of premium dollars.

Stop-loss arrangements are a form of insurance that provides protection for medical expenses above a certain limit, generally on a year-by-year basis. Stop-loss arrangements can be administered by the health plan or by independent insurance companies.

D. The Financial Impact of Risk-Sharing Arrangements on RBOs.

Risk arrangements were initially promoted as incentives for physicians to efficiently manage health care services. Incentives to manage care gradually evolved into provider contracts that shifted substantial financial risk for the provisions of non-physician health care services from health plans to the provider organizations. Today the dollars involved in non-physician service risk arrangements may equal or exceed the dollars involved in direct physician service risk arrangements even though risk-bearing organizations often do not maintain direct contracts with many of the providers that are charging costs against these risk arrangements.

The significant role that risk pool or shared-risk arrangements currently play in health plan-RBO contracting is evidenced by a review of the *pro forma* public contracts filed with the Department. Examples of the Divisions of Financial Responsibility (DOFR) contained in those contracts are shown at Exhibits I and II.

Despite the shifting or sharing of risk for most cost categories included in the sample DOFRs, the *pro forma* contracts on file with the Department tend to utilize general terminology such as institutional and ancillary risk, without identifying the specific services included or excluded under each risk arrangement. Similarly, current provider contract disclosures often do not identify the percentage of premium dollars allocated to each item of service enumerated in the DOFR nor do they generally describe in any detail the method of calculating the claims reimbursement for these

services. *Pro forma* contracts do not routinely identify whether hospital risk pools are segregated from other risk arrangements or whether multiple risk arrangements are offset against each other to arrive at a net risk pool payment to providers.

This lack of specificity in risk pool arrangement contract terminology, combined with the large volume of services and corresponding reimbursement flowing through these mechanisms, yields a product that involves substantial financial risk for RBOs.

Although risk arrangements have become increasingly complex, there is little research demonstrating the effectiveness of withhold and risk pool arrangements in altering physician conduct or controlling health care cost. For example, risk pools involving emergency room care are generally outside the control of the provider and therefore unaffected by physician practices, but appear to be routinely included in shared risk arrangements.

The limited data publicly available on the financial capacity of risk-bearing organizations to accept risk for the provision of health care services suggests that the greater an organization's reliance on risk pool revenue, the weaker the organization's balance sheet. In the recent issue brief, *Update on California Physician Group Solvency and SB 260*, prepared for the California HealthCare Foundation, the information presented indicates that the greater percentage of total assets that risk pool receivables represent on an organization's balance sheet, the weaker the group scores on basic financial measures of liquidity. This result is summarized in Table 1 below.

Table 1

Dependence on Risk Pool Receivables Spells Trouble

Risk Pools & Recoveries/Assets	Operating Margin	Cash Per Member	Cash Ratio	Current Ratio
0.15	0.00	$58.99	0.57	1.05
0.3	0.00	$49.15	0.37	0.86
0.45	-0.01	$39.32	0.18	0.67
0.6	-0.01	$29.48	-0.02	0.48

Source: An Update on California Physidian Group Solvency and SB 260 prepared for the California HealthCare Foundation by Paul J. Gertler, Ph.D., U.C. Berkeley and Christopher C. Ohman, MPA, CapMetrics, LLC

While the CMA's current lawsuit restricts the Department's release of the underlying financial data of RBOs, the HealthCare Foundation's finding does not appear inconsistent with the results of the Department's review of the first three quarters of RBO financial statements in 2001. Additionally, that review indicates that a significant number of RBOs are placing substantial reliance upon risk pool revenue. Specifically, roughly one-quarter of all groups display income statements where risk-pool revenues contribute greater than 10% of the group's total income (for this sub-group of RBOs, on average, over one-third of their total income is attributable to risk-pool revenue.) On the other hand, roughly one-half of all groups report risk-pool revenue making up less than 3% of total income.

Finally, it is worth noting that the "operating margins" shown for each of the categories of groups shown in Table 1 are very similar. However, while the operating margins are similar for each of these groupings, the effect of uncollected risk pool revenue on the operating margin of these groups may be very different. Should risk-pool revenue fail to materialize, the operating margin for groups placing more reliance on this category of income will likely be more dramatic. This potential negative effect of a significant loss in risk pool revenue for risk-pool reliant RBOs is likely compounded by the weaker than average balance sheets these groups, on average, maintain.

E. Historical Handling of Risk Arrangements

While the Department's predecessor promulgated no formal opinions or regulations on the subject of risk arrangements, the Department of Corporations ("DOC") did review the *pro forma* provider contracts filed by health plans, as well as individual provider contracts, to determine compliance with the Knox-Keene Act.

When reviewing the propriety of contractual provisions relating to risk arrangements, the DOC considered both the structure and the scope of the risk assumed by the provider organization. Below is a summary of DOC comments responding to a number of risk arrangement proposals and inquiries received prior to July 1, 2000. This sampling, taken from emails, letters and plan filings, does not necessarily reflect DMHC's perspective on risk arrangements.

- Generally, all risk arrangements were expected to approximate the cost of health care services covered under the division of financial responsibility. Artificially established budgets or budgets bearing no relationship to the cost of the services raised concerns under Section 1367 (h).

- Where the level of risk assumed under the risk arrangement was not commensurate with the size and financial stability of the provider group concerns were raised under Sections 1367(d)(e) and (f) and Rules 1300.51 and 1300.70(b)(2)(H)1.

- Undefined risk pool periods and open-ended risk arrangement were not permitted under section 1367(h).

- Generally, shared risk periods needed to be of sufficient length to ensure that medical decisions would not be based on economic considerations. Section 1348.6.

- To ensure that a provider's medical decisions were not inappropriately influenced by fiscal and administrative matters, "excessive" withholds and "onerous" risk pools, which could likely impact a provider organization's ability to timely pay claims or adversely impact the continuity of care of plan enrollees, were not permitted. Section 1367(g) and Rule 1300.67.3.

- The cumulative effect of all risk pools included in the plan/provider contract was considered. Generally, risk arrangements involving "down-side" risk of more than 20% of a group's total capitation were not considered appropriate.

- Risk arrangements that created a general incentive to deny or delay care were prohibited. (Health & Safety Code Section 1346.8) As such, the totality of an organization's withhold and risk pool arrangements was considered. If the magnitude of the risk assumed under the plan/provider contract would likely influence physicians to make clinical decisions based upon economic considerations the contract was not approved.

Finally, several restrictions were placed on the collection of risk pool deficits. The general logic behind those restrictions is summarized as follows:

- The Knox-Keene Act does not authorize a provider to accept risk or indemnify a health plan for health care services that are not provided pursuant to the providers' professional license. *See,* Health & Safety Code §§ 1345(f) and (i) and 1349.

- Capitation deductions to offset deficits in risk arrangements were prohibited since it could impermissibly impair the provider group's ability to provide current medically necessary health care services to plan enrollees in violation of Section 1375.1 and Rule 1300.75.1.

- Obligating a physician group to reimburse deficits stemming from hospital and other non-physician risk sharing arrangements through capitation deductions or other capitation adjustments resulted in the provider group's impermissible participation in global risk and were therefore prohibited.

However, at least on one occasion the DOC indicated that institutional risk pool deficits could be "collected" by: (i) offsetting institutional pool deficits against surpluses in other incentive or bonus programs; and (ii) passing institutional pool deficits forward against "future year program surpluses."

F. Board Discussion: One Possible Approach to Evaluating the "Appropriateness" of Current Risk Arrangements

Consideration of risk sharing arrangements is a complex topic. The topic is complicated further by a statutory/regulatory structure that provides limited guidance.

A suggested starting point for the discussion is Health and Safety Code Section 1349, which provides:

> It is unlawful for any person to engage in business as a plan in this state or to receive advance or periodic consideration in connection with a plan from or on behalf of persons in this state unless such person has first secured from the director a license, then in effect, as a plan or unless such person is exempted by the provisions of Section 1343 or a rule adopted thereunder…

Historically, licensed health care providers were impliedly exempted from the Section 1349 licensure requirements for services falling within the scope of their professional health care license. Unfortunately, little regulatory guidance evolved to define the scope of health care services that appropriately fell within the licensure of each individual health care professional.

Partially in response to the increasing scope of delegated financial risk for the provisions of health care services and partially in response to a number of well publicized medical group bankruptcies, the Legislature, as part of the enactment of SB 260 enacted Health and Safety Code Section 1349.3. This provision restated the general proposition, that a health plan may not contract with anyone but a licensed health care plan "for the assumption of financial risk with respect to the provision of both institutional and non-institutional health care services and any other form of global capitation."

While Section 1349.3 contained a *sunset clause* automatically repealing this provision on January 1, 2002, the import of this section - that whenever a physician organization is placed at financial risk for "institutional" health care services, it has wandered into the area of "global" capitation, which is a prohibited activity – remains current law. As such, additional guidance as to the meaning of "institutional", "non-institutional" and "forms of global risk" is still needed.

A starting point for the Board to study the "appropriateness" of risk arrangements begins with two threshold questions: (1) what constitutes institutional services; and (2) when has financial risk for institutional services been contractually assigned to a provider organization.

Beyond these definitional issues lies a more fundamental question – "What is the overall desirability of risk pool arrangements?" Given the uncertainty that surrounds the final dollar resolution of these pools, combined with funding levels that in many cases appear to be of the same magnitude as capitation, the financial exposure these arrangements impose on medical groups is substantial. Even if current structures of risk arrangements are deemed acceptable, it may still be appropriate to consider some restrictions on their scope.

With these broad issues in mind, the Department offers the following discussion points in an effort to elicit and focus Board member and stakeholder comments.

Discussion Point #1. What health care services are properly included in the concepts of institutional versus non-institutional services?

Current regulatory interpretation suggests that health plans cannot delegate the assumption of financial risk for "institutional" services to medical groups without effectively engaging in the prohibited practice of "global capitation." Before determining whether the risk associated with a given category of costs has been "passed" to a provider thereby creating a form of global risk, one must delineate which cost categories constitute institutional care.

Arguably, the brightest line for institutional risk is direct facility charges for both inpatient and outpatient services. Beyond this bright line appears a large gray area. In the past, the DOC has used Regulation 1300.67 (Scope of Basic Health Care Services) as a guide in this area. This regulation (a complete text of which appears at Exhibit 3) lays out the following seven categories of basic health care services that all plans are required to provide:

(a) Physician Services
(b) Inpatient Hospital Services
(c) Ambulatory Care Services (outpatient hospital services)
(d) Diagnostic Laboratory Services
(e) Home Health Services
(f) Preventive Health Services
(g) Emergency Health Care Services

While categories (a) physician services and (f) preventive health services appear to land clearly in the area of non-institutional physician risk, at least some portion of the remaining categories, depending on the evaluation criteria employed, could be deemed to constitute institutional services for this analysis.

One possible criterion for determining if a service category should be classified as institutional versus non-institutional would be to look to the physician organization's licensure. Specifically, any service for which the physician is licensed to perform would constitute non-institutional risk;

all remaining categories would default into the institutional category. (This classification exercise might actually result in the creation of a third category of services that are neither within physician licensure nor "institutional," i.e. pharmacy, DME. Whether it is "appropriate" for medical groups to be assigned risk for this third category of services is a potential separate topic for discussion.)

Which services described in Rule 1300.67 should be considered institutional services?

Discussion Point #2. When has financial risk been assumed by a provider organization for institutional services?

Once a determination is made regarding what constitutes institutional services, a determination must be made as to whether or not the financial risk associated with providing those services has been contractually assumed by a provider organization.

In determining what constitutes the actual assignment of financial risk for a given category of service, a review of common forms of risk arrangements currently in practice and some of the issues that they raise is helpful.

A. ***Basic capitation***. Should basic capitation be permitted for the costs associated with provision of any health care services identified above as institutional?

B. ***Pool that combines institutional and non-institutional services.*** A review of various DOFR's on file with the Department indicates that the costs associated with both institutional and non-institutional services are included within the same risk pool. Arguably, the potential effect of combining institutional service category losses against non-institutional gains results in a form of global capitation. Cross-service offsets are also similar to capitation payment deductions designed to collect hospital pool deficits; a practice the Department has generally prohibited.

C. ***Non-institutional or institutional pool that generates a deficit***. Reasonable risk pools dealing with either non-institutional or institutional costs that generate a surplus generally have not raised much controversy. Even if it is ultimately determined that the current general

restrictions related to the amount of dollars flowing through pools are appropriate, it still may be desirable to put some upper bounds on these arrangements. (See Discussion Point #3). However, if a pool generates a deficit, the method that a health plan uses to recover these deficits can generate issues. Some possible methods of recovery and the issues they raise include:

Offsetting a current year deficit against a current year surplus in a pool dealing with a similar category of costs (i.e., institutional against institutional, non-institutional against non-institutional) -- this approach raises no obvious issues.

Offsetting a current year deficit in a non-institutional pool against a current year surplus in an institutional pool, or vice versa – netting institutional vs. non-institutional costs potentially raises the issue described above in B.

Carrying forward a current year non-institutional pool deficit to subsequent years to offset any future non-institutional pool surpluses – netting non-institutional pools across years would not appear to raise an issue; creating a financial obligation in a subsequent year arguably constitutes an assignment of risk, but assignment of non-institutional risk generally is permitted.

Carrying forward a current year institutional pool deficit to subsequent years to offset any future institutional pool surpluses – netting institutional pools across years could raise an issue; arguably this practice creates a financial obligation in a subsequent year, and creating such a financial obligation might constitute an inappropriate assignment of institutional risk.

Collecting a deficit amount through deductions or withholds from future capitation amounts – deductions and withholds from future capitation payments to finance prior risk pool deficits has generally been a prohibited practice.

Discussion Point #3. Even if it is determined that the current basic structure of risk-sharing arrangements is "appropriate," should some limitations on their use be considered?

It may be determined that existing risk-sharing arrangement practices are "appropriate" and/or serve an important role in providing incentives to physician organizations. However, even if appropriate, it may still be desirable to consider developing some limitations on the use of these mechanisms. Some potential restrictions could include:

- The total funding of a specific pool could not exceed 5% (or some other specified percentage) of expected annual capitation revenues

- The total funding of all pools could not exceed 10% (or some other specified percentage) of expected annual capitation revenues