New Regulation May Expand the Scope of Payment Arrangements Subject to Knox-Keene Licensure

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The Department of Managed Health Care (DMHC) recently published a regulation that could dramatically expand the scope of a service plans for which a license is required under the Knox-Keene Act, the lega managed care in California. The regulation would upend the conventional wisdom that a license is only required g capitation or similar fixed, prep payments in exchange for providing or arranging for health care services, poten the licensure requirements to bu payment arrangements, accountable care organizations (ACOs), hospital risk po ents, and more.

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THE NEW REGULATION

The regulation, which the Department recently sent to the state Office of Administrative Law for finalization, applies the licensure requirement to a person that takes on "global risk" in exchange for a "prepaid or periodic charge." Though the statute has long referred to a "prepaid or periodic charge" for providing or arranging healthcare services, the new regulation breaks new ground by defining that term expansively: a "prepaid or periodic charge" includes compensation provided either ***at the start or end*** of a predetermined period that is "fixed either in amount ***or percentage of savings or losses in which the entity shares*** ." (28 C.C.R., proposed § 1300.49, subd. (a)(4) (emphasis added)).

The new regulation also makes clear that the licensure requirement applies when an entity takes on "global risk," which includes *both* institutional risk and professional risk. "Institutional risk," in turn, refers specifically to hospital inpatient and outpatient services, as well as hospital ancillary services, "other than services performed pursuant to the person's own license . . . ." Similarly, "professional risk" refers to physician, ancillary or pharmacy services. If an entity accepts a "prepaid or periodic charge" in order to take on "global risk," the entity is required to seek a license or an exemption. (28 C.C.R., proposed § 1300.49, subds. (b)(1) & (b)(2).)

In other words, under the new regulation, the licensure requirement is not limited to capitation arrangements, nor is it limited to pre-payments for services. Rather, any payment arrangement that involves ***any*** risk for both professional and institutional services may be subject to licensure if it involves a fixed payment or a percentage of savings or losses, even if it is calculated and paid after services are provided.

The regulation also formalizes a new category of licensure, a "restricted health care service plan," for an entity that does not market to the public or directly enroll individuals and instead takes on both institutional and professional risk for the provision of care to a defined population , under a contract with another health plan. The concept of a limited or restricted Knox-Keene license has already existed in practice for decades, so the new regulation simply codifies this.

Finally, the new regulation reiterates DMHC's authority to grant an exemption to the licensure requirement. It specifies the information DMHC should gather from an entity seeking an exemption, including financial information, number of enrollees for whom the entity will provide or arrange for care, the geographic scope of the operation, and "information on how the public interest or protection of the public, subscribers, enrollees, or persons subject to this chapter will be impacted if the person takes on global risk." (28 C.C.R., proposed § 1300.49, subd. (b)(2).) The regulation does not otherwise expand on the existing statutory standard according to which DMHC can grant an exemption. Under Health & Safety Code, section 1343, the Department can grant an exemption if doing so would be "in the public interest" and "not detrimental to the protection of subscribers, enrollees, or persons" regulated under the Knox-Keene Act.

THE NEW REGULATION'S EXPANDED LICENSURE REQUIREMENT

The Department's statutory authority to license health plans stems from Health & 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 . . . or unless such person is exempted . . . ." The interpretation set forth in the new regulation represents a significant departure from DMHC's longstanding interpretation that a license is required only where health care services are provided in exchange for fixed, prepaid compensation (i.e., capitated payments).

The new regulation's reference to a "fixed . . . percentage of savings or losses in which the entity shares" and compensation provided at the start or end of an arrangement suggests that an ACO arrangement may be subject to licensure, even where the contracted providers accept fee-for-service payment for their services and only experience limited upside or downside risk, calculated at the end of a period, in an effort to incentivize providers to engage in preventive medicine and provide high-quality care. In responses to comments received throughout the rulemaking process, the Department confirmed that an ACO may need to seek a license or an exemption from the Department.

Similarly, the new regulation suggests that a license may be required for a group of physicians that accepts capitation in exchange for the cost of its own professional services *and* agrees to take on some additional risk associated with their patients' additional health care needs, including hospital stays (i.e., hospital risk pools). Moreover, a license may be required under the new regulation where a group of providers accepts a single, bundled payment for professional services and any hospital fees associated with a single episode of care.

NEXT STEPS

Assuming the Office of Administrative Law approves the regulation, it will go into effect January 1, 2019. However, it applies ***only*** to contracts that are issued, amended or renewed after the effective date, so existing arrangements may not be immediately impacted, and some parties might consider amending their contracts before January 1, 2019, to extend their term, thus gaining additional time before the full impact of the new regulation is felt.

HLB encourages its clients that do business in California to review their payment agreements, particularly those that involve some upside or downside risk for the provision of health care services. For more information, please contact Stephanie Gross in San Francisco at 415.875.8500 or Charles Oppenheim in Los Angeles at 310.551.8100.

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