CLIENT ALERT

New DMHC Regulation Substantially Expands Number of Entities Requiring Knox-Keene Licensure

Mar.06.2019

The California Department of Managed Health Care ("DMHC") has promulgated a new general licensure regulation ("Licensing Regulation") that greatly expands the definition of what is considered a health care service plan ("Plan") requiring a license. The Licensing Regulation was approved by the California Office of Administrative Law on March 5, 2019 and is effective on July 1, 2019.

The Licensing Regulation formalizes current DMHC policy with respect to Plan-provider arrangements that trigger a licensing requirement, such as providers paid on a global capitation basis. In addition, the Licensing Regulation requires licensure, or an approved exemption from licensure, for arrangements such as medical groups receiving professional capitation along with shared risk or savings from hospital risk pool compensation, or providers that directly contract with employers under arrangements that include shared risk or savings compensation. As a result, this Licensing Regulation impacts providers, Plans that have provider contracts that could trigger a licensing requirement for a provider, and self-funded employers that contract with providers on a risk basis. The Licensing Regulation may also impact Medicare ACO arrangements.

Current Practice

Under existing law, a Plan is defined as:

> Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.[1]

A Plan license is required for entities offering coverage directly to individuals /families, employer groups, and government sponsored business (i.e. Medi-Cal managed care, Medicare Advantage).

Additionally, the DMHC requires provider entities (typically entities affiliated with hospitals or medical groups/IPAs) that contract with a licensed Plan for global risk, which has been loosely defined as both professional and institutional risk, to obtain a license as a Plan. Such licenses were initially called "limited" licenses but, since legislation passed in 1999 that placed a temporary moratorium on limited licenses, these Plan licenses are now referred to as "restricted" licenses. Functionally, a restricted license and a limited license are equivalent. Both licenses allow provider entities to take global risk under Plan contracts but not to contract directly with group, individual or government payers on a capitated basis.

Under current law, the application process for a restricted license is not defined. In practice, the DMHC requires the same exhibits for restricted and unrestricted license applications, except restricted license applications do not need to include exhibits for functions not delegated to it by an unrestricted Plan.

Licensing Regulation

The DMHC's Licensing Regulation in many ways adopts its current licensing practices. However, it also makes certain definitional changes that greatly expand the number of entities that will need obtain a license, both in terms of provider entities needing a restricted license because they take global risk from an unrestricted Plan, and in terms of provider entities taking global risk (under an expanded definition of risk) from self-insured employers. The DMHC has also included a process for entities to request an exemption from the licensure requirement.

Similarities

As with current practice, global risk is considered the assumption of both professional and institutional risk, and accepting global risk in return for arranging health care services requires licensure. Also, the exhibits required for a restricted license are based on the functions that are delegated to the restricted plan, consistent with current practice.

Differences

As noted above, licensure is triggered when an entity arranges health care services in exchange for a "prepaid or periodic charge." Throughout the 44-year history of the Knox-Keene Act, the term "prepaid or periodic charge" has generally been viewed as a premium (received from a group, individual or government payer) or capitation payment (received from a Plan), although the term is not defined by statute and, to this point, has not been defined by regulation. In a break from that tradition, the Licensing Regulation defines "prepaid or periodic charge" to mean:

> (A)ny 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.[2]

By including arrangements that include payments at the "end of a predetermined period" and "in amount or percentage of savings or losses," this definition greatly expands the scope of what is considered a "prepaid or periodic charge."

For example, if a medical group contracts with a Plan and participates in a hospital risk pool whereby the medical group receives some compensation from the hospital risk pool, even if it is only shared savings, such compensation would appear to constitute a "prepaid or periodic charge" for institutional services and would be considered institutional risk. Further, if the medical group also takes professional risk for the same members, the medical group would apparently be taking "global risk" within the meaning of the Licensing Regulation and would either need to obtain a restricted license or an exemption. Providers that participate in a Plan's ACO program that shares savings or risk between the Plan, hospital and group would also apparently be required to obtain a restricted license or an exemption, even though many of these arrangements were previously approved by the DMHC.

Similarly, if a medical group participated in "global risk" with a self-insured employer through a shared savings or other contractual risk-sharing arrangement, then the entity would likely need to obtain a full commercial license or an exemption.

Exemption Process

Instead of obtaining a license as a Plan, under the Licensing Regulation, an entity fitting the above description could request from the DMHC an exemption from the licensing requirement. Under the Licensing Regulation, the DMHC has 30 calendar days to respond to an exemption request. The documents to be submitted for an exemption request include:

- Exhibits describing the entity's financial condition and projected financial viability under the global risk arrangement;
- The percentage of annualized income of institutional risk the entity will assume and how it will be assumed;
- The contract for the assumption of global risk;
- The estimated number of subscribers and enrollees that will be served;
- The geographic service area under the global risk arrangement; and
- Any other relevant information.

When reviewing the exemption request, the DMHC shall consider the following:

- The entity's global risk business compared to its overall business;
- In the geographical region, the entity's market share for global risk compared to the competition and the potential for market disruption if the entity becomes insolvent;
- The entity's ability to assume global risk without jeopardizing enrollee access in the region;
- The impact on the market in the geographic region if the entity does not maintain solvency; and
- Whether the issuance of an exemption will negatively impact public interest or protection of the public, subscribers, enrollees of entities subject to the Knox-Keene Act.

Exactly how the DMHC will apply the Licensing Regulation to the information submitted by the entity requesting the exemption remains unclear. Presumably, the smaller the share of global risk business an entity has compared to its overall business, the chances of the DMHC issuing an exemption increase.

It is also likely that entities with a high degree of fiscal strength will have an advantage in requesting an exemption. The Licensing Regulation also indicates the exemption shall not negatively impact the public interest, a broad statement that would likely give the DMHC discretion in its review of an exemption request.

Grandfathering

The Licensing Regulation applies to contracts that are entered, amended or renewed on or after the effective date of the Licensing Regulation, which is July 1, 2019. As such, this should give entities a little time do decide how to proceed, which could be by submitting an application and obtaining a license, by submitting an exemption request and obtaining an exemption, or by eliminating the arrangement that causes the entity to trigger the licensing requirement.

Applicability to ACO arrangements with CMS

By its terms, the Licensing Regulation would seem to apply to Accountable Care Organization ("ACO") arrangements with the Centers for Medicare and Medicaid Services ("CMS"), including Medicare Shared Savings Program and Next Generation ACOs. However, the extent such ACOs are now required to obtain a license or an exemption is unclear based on the DMHC's Response to Comments for Comment Period Four ("Comment Responses"). In those Comment Responses, the DMHC indicated in several

places "(t)his regulation will not affect products licensed by the California Department of Insurance (CDI) or the Centers for Medicare and Medicaid Services (CMS). Therefore, the Department does not anticipate any conflicts or consistency issues with CMS or CDI regulated products or laws governing these entities." What this means is unclear since the DMHC licenses Medicare Advantage ("MA") Plans and currently requires restricted licenses for provider entities contracting with MA Plans for global risk. In addition, and despite the DMHC's representations in the Comment Responses, the Licensing Regulation does not include an exemption for CMS (or CDI) related arrangements.

Reasons for the Licensing Regulation and Its Impact

The DMHC's Final Statement of Reasons for the Licensing Regulation indicates that the regulation is necessary to set the level of assumption of financial risk that triggers a requirement to obtain licensure by the DMHC.

As part of its Final Statement of Reasons, the DMHC estimated there are 67 ACOs in California with two-thirds of those needing to obtain a license or an exemption. These ACOs would seem to include those contracted with the CMS as part of the fee-for-service program through a shared savings or Next Generation ACO arrangement, although the Licensing Regulation's applicability to these arrangements is unclear based the DMHC's Comment Responses, as discussed above.

In addition to ACOs, the DMHC indicated there are 21 Public Health Systems ("PHS") in California with one-quarter of those needing to obtain a license or exemption. The DMHC also indicated that it typically receives five restricted license applications in any given year. In the first effective year of the Licensing Regulation, the DMHC expects there could be up to 55 entities seeking licensure or an exemption.

Crowell & Moring is available to assist providers and Plans in developing strategies to address the Licensing Regulation, as well as entities that desire to seek licensure or an exemption from licensure.

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[1] Health and Safety Code §1345(f)(1)

[2] California Code of Regulations, title 28, section 1300.49(a)(4).

For more information, please contact the professional(s) listed below, or your regular Crowell & Moring contact.

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