# Default Risk Reserves: Options and Considerations

## Executive Summary

Default Risk Reserves are an important consideration for both Managed Care Organizations (MCOs) and providers in Value Based Payment (VBP) arrangements. Applying default risk reserves in a manner that is appropriately aligned with the VBP menu of options is vital to the success of New York State's transition to VBP.

***Policy Question:*** *Should state laws and regulations be amended to re-structure financial security deposits, escrow accounts, and contingency reserves so that there are adequate safeguards for the delivery system without inefficient cash reserves?*

VBP Level One introduces shared savings in addition to the traditional fee-for-service (FFS) payment structure. When providers achieve savings for an MCO and meet certain quality metrics, those providers will be reimbursed a portion of those savings. VBP Level Two retains the FFS payment structure and shared savings concept of VBP Level One, but contains two differences for providers: the opportunity for a higher percentage of shared savings and the potential for shared losses. VBP Level Three consists of prospectively paid options such as prepaid bundles and prepaid capitation. Because VBP Levels Two and Three involve risk sharing, considering them in the context of default risk reserves is important. The following options propose ways of answering this policy question in relation to VBP Levels Two and Three:

- Option 1: Reduce MCOs' Contingent Reserve Requirement and/or Escrow Deposit Requirements When Sharing Financial Risk
- Option 2: Create Alternative Arrangements for VBP Level Two that do not Include Provider Financial Security Deposits
- Option 3: Employ the Existing Default Risk Reserve Requirements to Both VBP Level Two and Level Three Arrangements

These options show that while the existing structure is useful, it may be beneficial to implement changes which will bring out this program's full potential for success.

Per option, the Subcommittee should recommend whether the State should set a *Statewide Standard* or a *Guideline for the methodologies employed between MCOs and the providers. The State will consistently employ a standard in its own approaches regarding methodologies and data dissemination to both MCOs and providers. The Subcommittee should recommend whether MCOs and providers should adopt the same standard or are free to vary, using the State's methods more as a guideline.*

- A Standard is required when it is crucial to the success of the NYS Medicaid Payment Reform Roadmap that all MCOs and Providers follow the same method.
- A Guideline is sufficient when it is useful for Providers and MCOs to have a starting point for the discussion, but MCOs and Providers may deviate without that harming the overall success of the Payment Reform Roadmap.

## Overview

The upcoming Subcommittee meeting will focus on developing policy recommendations for provider risk sharing and default risk reserves. These issues will require coordination between both the New York State Department of Health (DOH) and the New York State Department of Financial Services (DFS).

These issues are interrelated because default risk reserve requirements for providers are only relevant when providers are participating in risk sharing arrangements with insures such as MCOs. This brief will provide an overview of the regulatory framework that governs default risk reserve requirements for MCOs and providers. The brief will then present policy options for the Subcommittee's consideration. The policy options included in the brief are not exhaustive, and the Subcommittee is encouraged to consider alternatives outside of the options listed herein.

### Types of Risk

Each level of VBP changes the level of risk and type of risk to the MCO and provider. These variations of risk include:

*Insurance Risk*

VBP Level One does not present insurance risk for the providers as there is only upside shared savings with the existing FFS structure. Level Three (full capitation), however, is currently considered insurance risk as defined by Regulation 164.

VBP Level Two could be considered insurance risk if a provider taking on downside risk is concluded to be acting as an insurer. Comparatively, the equivalent version of VBP Level Two under the Medicare Shared Savings Program (MSSP) and the Pioneer ACO Model does not consider a provider taking on downside risk to be acting as an insurer from a federal standpoint. The Pioneer ACO Model sets a stop loss for the provider at 5-10% of the associated benchmark.

Providers under Level Two and especially Level Three may be at risk if a Medicaid member or group of members suffers a catastrophic event or significant change in health out of the control of the provider. Such events may need consideration when contracting between the MCO and provider to mitigate provider losses when the member's cost of care is greatly affected by factors the provider cannot control.

Consideration should be given as to whether VBP Level Two should constitute insurance risk.

*Absconding Risk*

As VBP Level One and Level Two are still paid on a FFS basis with an after the fact reconciliation, there is minimal risk of providers absconding.

In Level Three, however, prepaid capitated payments present the risk that providers will provide as few services as possible for Medicaid members. Outcome measures are designed to combat this possibility, but additional safeguards should be considered.

*Performance Risk*

Providers run the risk that other providers within the PPS will not perform adequately which will result in trickle down losses. In Levels Two and Three, a provider may be reliant on the performance of other providers to perform efficiently in order to avoid losses and achieve savings.

***Default Risk Reserves***

Default Risk Reserves fall into two categories: (1) Requirements for MCOs and (2) Requirements for Providers. The requirements for MCOs include the *escrow deposit* and the *contingent reserve requirement*. The Requirement for Providers is the *financial security deposit* as required by Regulation 164, barring any exceptions or exemptions.

Requirements for MCOs*:* The purpose of the MCO Deposit Requirements is to ensure that MCOs are capable of fulfilling their obligations to reimburse providers after they have received premium income from the State. These requirements provide the State some assurance that MCOs are financially sound.

a. *Escrow Deposit* – A deposit in a bank account that represents a percentage of the projected medical expenses the plan will disburse in a given year. The requirement is *5 percent* for mainstream Managed Care (MMC), but differs based on service line. The deposit amount is updated annually on April 1st.

b. *Contingent Reserve Requirement* – This requirement is not a 'deposit' but a calculation of the MCO's net worth as a percentage of the MMC premium income received by the plan in the previous year. Net worth is calculated using Statutory Accounting Principles which significantly reduces the value of illiquid assets (e.g., buildings, unlikely receivables, and intangibles) and provides a slimmer picture of the MCO's net worth. This percentage is recalculated quarterly to help the state monitor a MCOs' short-term financial health. The contingent reserve requirement currently stands at *7.25 percent* for MMC, but differs depending on service line.

Requirements for Providers: The *financial security deposit* is a requirement under DFS Regulation 164 and the DOH Provider Contracting Guidelines for providers incurring financial risk. DFS narrowly defines significant financial risk in regulation as prepaid capitation arrangements. Financial risk arrangements that do not involve capitation are regulated by DOH. Similar to MCO requirements, the financial security deposit helps ensure that providers maintain the financial wherewithal to fulfill their commitment to Medicaid members and MCOs once they receive prepayments from plans for providing those services.

c. *Financial Security Deposit* – This requires that providers submit a deposit to plans equal to *12.5 percent* of the annual estimated revenue received from the plan under the risk arrangement. This deposit can take the form of a letter of credit, securities in a trust, funds held, or a provider stop loss arrangement with another insurer.[1] DOH has indicated that the MCO fulfills this requirement on behalf of the

[1] Certain forms of deposit such as letters of credit are limited to 50% contributed to the deposit requirement. The remaining 50% must be in the form of another source of funds such as cash.

providers in some instances. We are continuing to work with both DOH and DFS to discuss these issues.

***VBP Considerations***

Providers take on risk under VBP Level Three arrangements with a fixed capitated amount paid by the MCO to the provider to cover a single episode, condition, or the total cost of care of for a Medicaid member. Under VBP Level Three, the provider accepts unlimited financial risk in exchange for a potentially favorable financial outcome compared to the traditional FFS reimbursement model. MCOs have potentially heightened risk because of the unlimited financial risk assumed by the provider (e.g., the MCO may be more likely to incur additional costs if a provider defaults and cannot meet its patient care obligations).

Under VBP Level Two arrangements, the provider accepts some financial risk[2] in exchange for the opportunity to obtain a greater share of cost savings from the MCO. The risk of provider default is greatly limited when compared to prepaid capitated arrangements. Because FFS claims are still being paid on a regular basis throughout the performance period, there is limited risk that insurers will need to provide additional reimbursement compared to claims that were prepaid through capitation. Risk of provider default is higher under VBP Level Two compared to traditional FFS and VBP Level One because providers who underperform at VBP Level Two (i.e., providers who consistently exceed the bundle benchmark in costs) may not have the financial resources to cover their portion of the shared losses.

## Policy Question

*Should state laws and regulations be amended to re-structure financial security deposits, escrow accounts, and contingency reserves so that there are adequate safeguards for the delivery system without inefficient cash reserves?*

Options One and Two below will consider this question within both the context of VBP Level Three prepaid arrangements and VBP Level Two reconciliation based arrangements. Option Three includes considerations only for VBP Level Two reconciliation based arrangements.

[2] Either in the form of reduced claim reimbursements from the MCO or an amount payable to the MCO.

**Option One**

***Reduce MCOs' Contingent Reserve Requirement and/or Escrow Deposit Requirements When Sharing Financial Risk***

Option one is to modify MCOs' Contingent Reserve and Escrow Requirements to reflect the added security that providers contribute to ensure their ability to meet their obligations in risk sharing arrangements. This would apply to both VBP Level Two reconciliation based arrangements and VBP Level Three prepaid arrangements.

| Pros | Cons |
|---|---|
| This option would allow plans greater flexibility to use premium dollars to invest in additional programs or other business activities. Having lower reserve requirements may also decrease the pressure for higher premiums. | Decreasing reserve requirements for insurers may increase the State's risk exposure if insurers default on their obligation to reimburse providers for medical services. This risk is compounded if several providers in risk based arrangements with the same plan default on their obligations. The risk of provider default is somewhat mitigated by the financial security deposit requirement placed on providers. |

**Option Two**

***Create Alternative Arrangements for VBP Level Two that do not Include Provider Financial Security Deposits***

The financial security deposit requirement placed on providers engaging in prepaid risk arrangements may be unnecessary in VBP Level Two arrangements because they involve retrospective reconciliations that have limited potential downside.[3] The sub-options listed below consider alternative requirements for providers engaging in VBP Level Two arrangements.

A. Allow providers to engage in VBP Level Two arrangement without a financial security deposit.

| Pros | Cons |
|---|---|
| This sub-option would encourage participation in VBP because providers would be able to participate without bearing the financial burden of satisfying this requirement. | There are still financial risks on providers associated with VBP Level Two arrangements. Providers who underperform in VBP Level Two may experience cash flow problems compared to FFS or VBP Level One. |
| This would avoid the complications that would arise from having to calculate appropriate reserve requirements based upon VBP Level Two arrangements. | |

[3] Limited potential downside refers to the limit on the amount of risk sharing and financial loss incurred by a provider when it exceeds the contractual bundle benchmark amount.

B. Refuse to impose the financial security deposit requirement for VBP Level Two Arrangements, but require additional safeguards. Safeguards might include protection for providers against catastrophic events in their populations and withholds to relieve the burden of cash flow fluctuations from reconciliation payments.

| Pros | Cons |
|---|---|
| This sub-option would encourage participation in VBP because Providers would be able to participate without bearing the financial burden of satisfying the full insurance/Reg 164 requirements. | A State imposed withhold could be duplicative or unnecessary if there is a contractually imposed withhold from the plan. |
| This would avoid the complications that would arise from having to calculate appropriate reserve requirements based upon VBP Level Two arrangements. | Providers may be reluctant to move from VBP Level One to VBP Level Two if there are too many restrictions beyond the downside risk (e.g., a withhold from FFS payments could reduce cash flow compared to VBP Level One and make it less desirable). |
| This sub-option would also help to mitigate risks on providers from catastrophic events and cash flow issues. | Development of additional safeguards may be cumbersome and would likely require additional monitoring and evaluation requirements to ensure the safeguards are sufficient. |

**Option Three**

***Employ the Existing Default Risk Reserve Requirements on Both VBP Level Two and Level Three Arrangements***

The existing regulatory structure would continue to require a financial security deposit from providers and an escrow deposit and contingent reserve requirement from plans at the current regulatory amounts. Regulation 164 would require additional language to define VBP Level Two downside risk sharing as a transfer of financial risk. This expansion of Regulation 164 would be in addition to any financial security deposit requirements that the DOH requires.

| Pros | Cons |
|---|---|
| The escrow deposit and the contingent reserve requirement placed on MCOs help ensure that MCOs are in adequate financial position to fulfill their obligations to reimburse providers once they receive premium payments from the state. | Especially in VBP Level Two, these requirements represent restrictions on MCOs' use of assets and limit their ability to use those assets in other business activities. Higher reserve requirements may also require higher premiums for MCOs to fund those reserves. |
| The financial security deposit ensures that MCOs have a financial backstop in cases where providers default on their obligations and the MCO must step in to ensure uninterrupted patient care. | It may be duplicative (especially in VBP Level Two arrangements) to require providers to develop a financial backstop for their prepaid obligations from plans when plans are also required to develop a financial backstop for their obligations to the state. |
| | There is not currently a method available for calculating a provider or MCO's risk exposure from a VBP Level Two arrangement. |