Provider Risk Sharing: Options and Considerations

Executive Summary

Provider risk sharing is a key component of Value Based Payment (VBP) arrangements. The Regulatory Impact Subcommittee (Subcommittee) is tasked with providing recommendations regarding the policy question and related policy options below which deal with the regulatory and procedural framework surrounding provider risk sharing.

As stated in the VBP Roadmap, NYS Medicaid VBP will include three levels. VBP Level One involves fee-for-service (FFS) payment plus shared savings (upside only) and is therefore not relevant for a discussion around risk sharing. 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 (downside risk). Because Level Two involves retrospective reconciliation of payments to determine whether there are savings or losses, it represents a grey area in the regulatory framework. VBP Level Three involves prepaid bundles (chronic and episodic) and other prepaid capitation arrangements.

The following policy options have been developed for the Subcommittee's consideration.

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.

Policy Question: *Are the regulatory requirements that are in place for providers taking on downside risk appropriate for the transition to VBP, or should some alternate regulatory vehicle(s) be developed?*

- Option 1**:** Leave Regulation 164 as it currently stands. Apply the requirements of Regulation 164 to VBP Level Three Arrangements but not to Level Two arrangements. The DOH review process for risk-sharing arrangements would remain in place, but would be modified to address the VBP Levels.

- Option 2**:** Modify Regulation 164 or enact new regulations to develop separate requirements for VBP Level Two arrangements that mitigate business and cash flow risk.

- Option 3: Apply the requirements of Regulation 164 to all VBP Level Two and VBP Level Three arrangements and broaden the definition of Financial Risk Transfers to also include VBP Level Two.

In considering these options, the Subcommittee should also recommend the degree of State involvement required and related considerations and regulatory impacts associated with each option.

Overview

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

These issues are interrelated because Default Risk Reserve requirements that are placed on providers are only relevant when providers are participating in risk sharing arrangements with insurers such as Managed Care Organizations (MCOs). This brief will provide an overview of the regulatory framework that governs provider risk sharing. 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.

Provider Risk Sharing

Provider risk sharing occurs when a provider accepts the possibility of a financial loss in exchange for the opportunity to gain a larger share of cost savings with an MCO. DOH defines "Risk Sharing" as contractual assumption of liability by a provider or IPA for the delivery of health care services and may be by means of capitation or some other mechanism such as a withhold, pooling, or postpaid provisions. DOH financial review and approval is required for all MCO agreements that transfer financial risk for services to another entity, except for prepaid capitation which falls under Regulation 164 and DFS review.

Stop-Loss Agreement

Physician Incentive Plan (PIP) refers to any compensation arrangement to pay physicians or physician groups that may have the effect of reducing or limiting the services provided to any plan enrollee. If a Contractor elects to operate a PIP, the Contractor agrees that:

1. No payment will be made to a Provider as an inducement to reduce or limit medically necessary services to an Enrollee.

2. If the PIP places physician(s) at a substantial financial risk for services that it referred but did not furnish, for an amount beyond the risk threshold of 25% of potential payments for covered services, the MA Organization must assure that all physician(s) at risk have a stop-loss agreement in place.

3. Contractor agrees to submit to DOH annual reports containing the information on its PIP in accordance with 42 CFR §§ 438.6(h), 422.208 and 422.210.

DOH Regulatory Framework

In any risk sharing arrangement, the MCO ultimately retains its statutory obligation to maintain full risk under NYS PHL § 4403(1)(c) on a prospective basis for the provision of comprehensive health services pursuant to a subscriber contract or governmental program. MCOs are obligated to obtain approval from DOH in accordance with the regulations and Provider Contract Guidelines and from DFS in accordance with Regulation 164 prior to entering into a risk sharing arrangement. IPAs may share risk for the provision of medical services with MCOs, and to subcapitate or otherwise compensate providers and IPAs with which it has contracted.

All contracts require submission of a contract certification statement and a non-financial review to DOH for compliance with all provider contracting guidelines. Current DOH Financial Review Criteria for Specific Non-Prepaid Arrangements:

- ***DOH Level 1*** – Level One involves FFS contracts with providers and IPAs. This arrangement includes withholds or bonuses up to 25% of payments to the provider. Providers do not need to demonstrate the provider's financial viability or establish a financial security deposit.

- ***DOH Level 2*** – Level Two involves contracts that transfer financial risk (capitation) to providers for single specific service provided directly (e.g., primary care (except inpatient hospitalization) with the provider accepting all medical risk for that service). Providers do not need to demonstrate the provider's financial viability or establish a financial security deposit.

- ***DOH Level 3*** – Level Three involves contracts that transfer broader risk to providers (multiple services provided directly, inpatient hospitalization, or fee-for-service with withholds or bonuses of greater than 25%). Providers must demonstrate their financial viability. If the provider or the parent companies have a positive net worth, no financial security deposit is required. If the provider or the parent companies have a negative net worth, a financial security deposit must be established based on the provider's in-network cost.

- ***DOH Level 4*** – Level Four involves contracts that transfer risk to IPAs for a single service or multiple services. Such contracts must demonstrate the IPA's financial viability and there is a requirement to establish a financial security deposit.

Regulation 164 (DFS)

DFS Regulation 164 provides guidance concerning the Financial Risk Transfer arrangements and outlines the requirements for providers that do not obtain an insurance license to enter into such arrangements. Regulation 164 states that unless the financial security deposit (FSD) requirement is met, providers are barred from entering into an agreement to share financial risk through a capitation arrangement with either an insurer or any entity certified pursuant to Article 44 of the New York State Public Health Law. The purpose of the FSD is to ensure that providers are financially stable and are able to fulfill their commitment to Medicaid members following the receipt of prepayments from plans for providing those services.

Within the context of VBP, providers are sharing risk with MCOs under Level Two and Level Three VBP payment arrangements.

- ***VBP Level 2*** - Under Level Two arrangements, FFS claims are still being paid on a regular basis throughout the continuum of care; however, there is a risk sharing component. The providers' reimbursements from an MCO are reduced, up to a set cap, for amounts they claim over a contractual benchmark amount for a particular bundle or PMPM. Therefore, providers are still responsible for fluctuations in healthcare costs, which can lead to a higher risk of provider default caused by a providers' underperformance.

- ***VBP Level 3*** - Under Level Three arrangements, the providers are paid a fixed capitated amount by an MCO, but the providers assume unlimited financial risk as the providers agree to incur responsibility for the total care of a Medicaid member. This arrangement requires establishing episodic bundles or capitation prices at the beginning of the contracting period.

DFS requires that providers who enter into prepaid capitation arrangements and are considered to be "in the business of insurance" must engage in one of two activities. The providers must either:

1. Apply to become an insurer and obtain an insurance license; or

2. Comply with Regulation 164.

However, current Level Two VBP arrangements are a regulatory grey area because these arrangements do not involve prepaid capitation, yet they still place providers in the position of potentially having downward reconciliations for poor performance. Therefore, it is important to consider whether VBP Level Two arrangements qualify as the business of insurance under New York State insurance law and regulations and, either way, whether alternative regulations need to be considered for governing such arrangements.

Policy Question:

Are the regulatory requirements that are in place for providers taking on downside risk appropriate for the transition to VBP, or should some alternate regulatory vehicle(s) be developed?

The options below will consider this question primarily within the context of VBP Level Two arrangements, which may significantly limit the downside exposure for providers.

Option One

Leave Regulation 164 as it currently stands. Apply the requirements of Regulation 164 to VBP Level Three Arrangements but not to Level Two arrangements. The DOH review process for risk-sharing arrangements would remain in place, but would be modified to address the VBP Levels.

Under VBP Level Two arrangements, providers may be held responsible for factors outside of their control (e.g., the poor performance of other providers within their network or an epidemic), but the loss would be capped. Furthermore, even with provider underperformance, the healthcare delivery risks primarily remain with the insurer. Therefore, the Subcommittee may consider excluding Level Two arrangements from Regulation 164 definition of *financial risk transfer*. The DOH contract review process and requirements would remain, but be modified to reflect the VBP Levels.

Pros	Cons
Providers would not be subject to the risk sharing requirements with MCOs and, if excluded from the definition of *financial risk transfer*, providers who engage in Level Two arrangements would be absolved of the FSD risk sharing requirement.	There would be uncertainty regarding providers' ability to repay insurers for underperformance which could drive up future healthcare delivery costs.
There would a reduced likelihood of excess cash reserves sitting idle.	New regulations or considerations would need to be considered and developed to address this gap.

Option Two

Create or amend regulations to include alternative risk sharing requirements, particularly for VBP Level Two.

Modify Regulation 164 or enact new regulations (whether in the insurance, health, or other titles) to develop separate requirements for VBP Level Two arrangements that mitigate business and cash flow risk.

Pros	Cons
Developing separate, less burdensome requirements for providers sharing risk under a VBP Level Two arrangement would encourage provider participation by allowing flexibility from the insurance and/or Regulation 164 requirements.	This method will require the development of new or revised regulations, safeguards, and may even require legislative support. It may be difficult to obtain consensus on the requirements from all stakeholders.
Developing specific safeguards that mitigate risks inherent to a VBP Level Two arrangement would still ensure that providers are capable of fulfilling their obligations to Medicaid members.	

Option Three

Apply the requirements of Regulation 164 to all VBP Level Two and VBP Level Three arrangements and broaden the definition of Financial Risk Transfers to include VBP Level Two.

The current definition of *financial risk transfer* under Regulation 164 does not address the concept of VBP Level Two arrangements. Because Level Two is not a prepaid capitation arrangement, the existing regulatory structure would not include Level Two arrangements under the current definition as it stands, and it would remain unclear whether Level Two would constitute a transfer of financial risk. We request the Subcommittee to consider whether the requirements of Regulation 164 should be modified to include Level Two arrangements by changing the definition of *financial risk transfer* along with other related changes that may be needed to effectuate this change.

Pros	Cons
Providers under Level Two arrangements could utilize Regulation 164 to avoid the potential application of full insurance requirements.	There is a risk of duplicative coverage for the same risks depending on how the "financial risk transfer" is defined.
There would be a reserve in place to cover potential losses (downside risk) and help protect the provider and MCO.	Providers may have a financial security deposit requirement despite payments from MCOs occurring on a retrospective, FFS basis.