



Value Based Payment Arrangements Involving Risk Sharing

Other State Examples

This brief contains five examples of other states that have designed programs similar to New York's VBP arrangements and under which are allowing providers to take on downside risk. For each example, a summary of the system protections and restrictions on the provider risks are provided.

Oregon

Oregon began a Medicaid Redesign Program in 2012 which will end in 2017. A main feature of the Oregon Medicaid Demonstration (2012) is the transition in organizational structure from Oregon's traditional Managed Care Organizations (MCO) to Coordinated Care Organizations (CCO). A CCO is an MCO that is comprised of a network of health care providers (physical health care, addiction and mental health care, and dental care providers) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid).

CCOs will be reimbursed through a trended global budget that represents the total cost of care for the full continuum of Medicaid services. CCOs will be responsible for bearing the full financial risk associated with cost of care within the global budget.

In Oregon, all CCOs are MCOs that are legally and financially capable of taking on downside financial risk.

Tennessee

Tennessee began its State Innovation Model (SIM) in 2013 to change the way that health care is paid for in Tennessee from volume to value based. In December 2014, the Centers for Medicare and Medicaid Services (CMS) awarded Tennessee \$65 million SIM grant. The purpose of this grant is to assist the state in making health care a value-based system. Recently-enacted changes to its health maintenance organization (HMO) licensure statute expressly allow for risk-sharing arrangements between HMOs (including TennCare MCOs) and physician-hospital organizations, other providers or provider groups, or provider networks.

One strategy that the state outlined in their application for the SIM to CMS is to begin paying providers based on retrospective episodes of care. Unlike prospective payments such as bundled payments, episodes can be implemented for small and large providers, independent providers and integrated Accountable Care Organizations, urban and rural, without any changes to providers' infrastructure or business relationships.

Provider risk is handled by allowing different combinations of providers (PCMH) to take on episodes of different size. Different approaches to PCMH payments make sense for providers with different sized patient panels, different levels of PCMH readiness, and urban and rural providers. Therefore, the initiative will not set a single payment approach but will create a menu of options for providers and payers to agree upon.

A Principal Accounting provider (PAP) or a provider “Quarterback” will be designated to participate in the risk-sharing episode arrangements. The Quarterback is the provider in best position to influence quality and cost of care. The plans will share 50/50 gain-sharing and risk-sharing with providers for all episodes. There does not appear to be any specific regulation and/or requirement to protect against provider risk.¹

Colorado²

In 1994, the Colorado General Assembly passed HB 94-1193 which authorized the commissioner, through regulation, to set forth standards and requirements specific to “licensed provider networks.” Provider networks desiring to provide only a limited health service and only assume the level of risk commensurate with those limited benefits can be licensed as a limited service licensed provider network pursuant to the Colorado Division of Insurance (DOI) 3 CCR 702-2 Amended Regulation 2-1-9.

Rather than applying with the DOI for licensure as an insurance company, a provider network may alternatively apply for licensure as a Limited Service Licensed Provider Network (LSLPN). In order to be eligible, a provider must agree that in the event a member of the network is unable to provide services, the network will be obligated to provide the services.

Requirements:

- 1.) An application to be licensed as a LSLPN must be filed by the provider network and submitted with a \$500 non-refundable fee.
- 2.) A detailed summary of its proposed business plan as an LSLPN must be filed with the Commissioner.
- 3.) Biographical sketches of all proposed officers, directors, owners and organizers.
- 4.) A current audit, certified by an independent CPA, of its financial condition in addition to three years of financial projections.
- 5.) Various other documents and certifications.

¹ <http://www.tn.gov/assets/entities/hcfa/attachments/ProjectNarrativeTNSIMgrant.pdf>

² <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheadname1=Content-Disposition&blobheadname2=Content-Type&blobheadervalue1=inline%3B+filename%3D%222-1-9+Concerning+the+Licensure+of+Limited+Service+Licensed+Provider+Networks.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251815005640&ssbinary=true>



Standards:

- 1.) Maintain an unqualified annual audited financial report certified by a CPA.
- 2.) Demonstrate financial stability by maintaining a minimum net worth, excluding goodwill and intangibles, equal to the greatest of (i) \$100,000 (ii) two times the authorized control level of the most recent risk based capital calculation, or (iii) such other amount determined by the commissioner.
- 3.) Network adequacy and quality requirements.

Statutory Deposit:

Each LSLPN shall deposit securities in an amount based on enrollment levels.

- 1.) \$300,000 for enrollment less than 60,000
- 2.) \$350,000 for enrollment of 60,000 but less than 100,000
- 3.) \$400,000 for enrollment of 100,000 or more

California

Under the Knox-Keene Health Care Service Plan Act of 1975, a Knox-Keene licensed health plan that has capitated contracts with provider groups is responsible for monitoring provider solvency. After the failures of many health care provider groups in the late 1990s, the state passed Senate Bill 260 (SB 260) in the fall of 1999. The legislation was intended to force provider groups to maintain certain solvency standards and improve their financial reporting management.

SB 260 Reporting Requirements:

All Risk-bearing Organizations (RBOs) must provide a quarterly financial survey report to the California Department of Managed Health Care containing the following:

- For organizations serving at least 10,000 covered lives:
 - Financial survey report prepared in accordance with GAAP
 - Certain information about claims paid and estimated, net equity and working capital, and cash to claims ratio
- For organizations serving less than 10,000 covered lives:
 - Certain information about claims paid and estimated, net equity and working capital, and cash to claims ratio
- For all organizations, regardless of covered lives an annual report is required including various financial information and a “Statement of Organization Survey”

SB 260 Four Grading Criteria:

- 1.) Maintained positive working capital at all times

- 2.) Maintained positive TNE at all times
- 3.) Has calculated and documented IBNR
- 4.) Has reimbursed, contested, or denied at least 95 percent of its claims within 45 working days

Any RBO reporting deficiencies in any of the four grading criteria are required to implement, with the agreement of their contracting health plans and the approval of the Department, a Corrective Action Plan to remedy these deficiencies so that the organization is compliant with SB 260.

Plans are required to provide certain information to the RBOs in their network including enrollee information on a monthly basis, allocated amounts to the provider every 45 days, and additional disclosures.



CA RBO Regulation
Summary.pdf

Massachusetts

The Massachusetts health care payment reform law, Chapter 224 of the Acts of 2012, became effective on November 4, 2012. Chapter 224, in part, created the new Chapter 176T, under which the Massachusetts Division of Insurance (the Division) must annually certify provider organizations that take on certain financial risk through alternative payment contracts with Carriers, or Risk Bearing Provider Organizations (RBPOs).

The regulation is designed to increase the oversight of RBPOs and to require their “Risk Certification” by the Division. In its application for a “Risk Certificate,” the RBPO must submit, along with an application fee, certain financial information and statements, including a list of all carriers and public health payers with which the provider organization has entered or intends to enter into Alternative Payment Contracts with Downside Risk, as well as an “actuarial certification” that shows that its Alternative Payment Contracts with Downside Risk are *not* expected to threaten the financial solvency of the RBPO. A RBPO may receive a “Risk Certificate Waiver” if it can demonstrate that it is not taking on significant downside risk.

“Downside Risk” is defined in 211 CMR 155.00 as the, “...risk taken on by a Provider Organization as part of an Alternative Payment Contract with a Health Care Payer, Employer or Individual in which the provider organization is responsible for either the full or partial costs of treating a group or patients that may exceed the contracted budgeted payment arrangements.” The division does not, however, consider service based-payments, including but not limited to, diagnostic-related group payments, “per diems” or bundled payments, to constitute Downside Risk under Chapter 176T.



MA RBPO Bulletin
May 2014.pdf

Summary

State	How is the system protected against provider risk?	How are they restricting provider’s ability to risk share?
Oregon	The providers are licensed insurers.	They do not; CCOs are fully responsible (page 2 CCO Model).
Tennessee	None identified.	Risk sharing is only allowed for a menu of “episodes.”
Colorado	The providers are licensed as an alternative LSLPN that provides various requirements.	Only provider networks that desire to provide a limited health service and only assume the level of risk commensurate with those limited benefits can apply as an LSLPN.
California	Certain requirements must be met quarterly for a provider to remain a RBO.	Only those providers that meet certain solvency standards are able to partake in risk sharing.
Massachusetts	Providers must apply to become a RBPO which includes various requirements.	Only those providers that meet the requirements to become an RBPO can partake in risk sharing.