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Date: March 14, 2002
To: ALL INTERESTED PARTIES
From: Department of Managed Health Care

The following is a brief summary of the comments and events that occurred during the Financial Solvency Standards Board (FSSB) meeting February 28, 2002.

I. Introduction: Opening remarks by Scott Syphax, Chair

1. Prior meeting minutes were approved and adopted by the Board members.

**II. Presentation Regarding Risk Arrangements by Lawrence Casalino, M.D., Ph.D.,
Department of Health Studies, University of Chicago**

1. Dr. Casalino presented results from his research on risk arrangements. His research, based on the Center for Studying Health Systems Change's Community Tracking Study, included both survey and site visit components. Highlights from his presentation are as follows:

- a. On a national level, risk contracting is declining in most markets with fewer plans using risk contracting and fewer patients in risk contracts.
- b. Risk contracting is being modified in other markets for reasons other than risk regulation.
- c. The decline in risk contracting may be due to consumer backlash resulting from incentives to withhold care, "tight" provider networks and overzealous utilization management. In addition, hospitals and specialists have consolidated to increase leverage with HMOs.
- d. California's health care delivery model, with a significant number of provider organizations capable of managing care, does not track with the national trend. Twelve community-tracking sites average not much more than three groups of twenty physicians per site.
- e. Besides MedPartners and FPA failures, there have been only a limited number of medical group bankruptcies.
- f. It is necessary to have competition among physicians groups based on cost and quality. California generally is farther along in this area than other states except perhaps Minnesota.

- g. Health care dollars should track with the coordination of care, across the whole continuum of health care services, including hospitals, acute hospitals, primary care services, outpatient care.
- h. With proper safeguards, pricing and reserves, the global capitation model is best suited to control health care costs.

III. Representative from Centers for Medicaid and Medicare Services Discussing Federal Rules or Restrictions on Downstreaming of Risk

1. Ms. Nancy Kitchen, Health Plan Benefits Group, Centers for Medicaid and Medicare Services in Baltimore and Greg Schneider, HMO contract manager, San Francisco regional office discussed federal oversight of financial solvency of medical providers. Generally, CMS does not review the financial solvency of medical providers who accept financial risk from managed care organizations contracting with CMS to provide care to Medicare beneficiaries. As long as the respective state regulatory agency considers the managed care organization to be in compliance with requirements for fiscal soundness, the managed care organization is eligible to contract with CMS. CMS operates as purchaser rather than a regulator. This is consistent with CMS' practice of monitoring, but not regulating the financial condition of managed care organizations that contract with CMS.

2. Although CMS does not monitor the financial condition of subcontracting medical providers, they do require stop loss protection for provider organizations that assume substantial financial risk determined to be in excess of 25% of its capitation revenue.

3. CMS requires managed care organizations or any of its contractors or subcontractors that use the physician incentive plan that may affect the use of referral services or the types of incentive arrangements to provide detailed explanations to Medicare beneficiaries regarding these arrangements upon request.

4. The CMS web site <http://www.hcfa.gov/medicare/physincp/pip-info.htm> has more in-depth discussion of required physician incentives.

IV. Risk Arrangement Working Group Status Report

1. The Working Group set out as its goal the development of recommended guidelines for risk sharing arrangements between health plans and risk-bearing organizations.

2. The group identified the following areas of focus: institutional risk; other high cost, highly variable expense areas; downside risk and netting of risk pools that cover different services.

3. Input was solicited from health plan, risk-bearing organization and consumer representatives.

4. Following the receipt of stakeholder input, The Working Group met to develop draft recommendations. The key findings were as follows:

- a. When structured and managed effectively, risk sharing arrangements provide the financial incentives that create efficiencies, lower health care costs and improve patient satisfaction.
- b. It is important to continue to allow RBOs to participate in a significant way in inpatient hospital risk pools.
- c. There should be a mechanism for RBOs to reinsure high cost, highly variable expenses.
- d. Netting of separate risk pools should be prohibited. All expense areas that are combined for settlement purposes should be incorporated in a single risk pool.
- e. There is no stakeholder consensus on the issue of allowing downside risk in risk sharing arrangements.
- f. There is some stakeholder consensus that RBOs that meet solvency requirements should be allowed to accept greater downside risk.
- g. There is a strong stakeholder consensus that the new plan reporting requirements should increase the accuracy of risk pool receivable reporting.
- h. There is strong stakeholder consensus that any clarification or tightening of rules related to risk sharing arrangements should be phased-in as contracts between plans and RBOs are renewed.

Public Comment:

Provider perspective: Consumer are: (1) concerned with the implications for consumers in terms of disruption of care, adequate access to specialists and other services; (2) pleased to hear there are improvements, but how wide spread is it that these risk pools have been used to create urgent care clinics or are these isolated incidents; (3) some arrangements seem to cross the line into global risk sharing; (4) risk sharing is a way to circumvent the prohibition on global risk and supportive of the limit of downsize risk of no more than 20 percent; and (5) scope of practice exemption and licensure of individual health professionals apply to the individual and not to the entity. RBOs should be licensed not only for reasons of solvency, but also for quality of care, including infection control, appropriate staffing, timely access of care.

Medical group perspective: Providers are: (1) troubled by the continuing concern that plans are utilizing illegal risk sharing agreements or global capitation arrangements. (If such arrangements exist they should be disclosed and examined); (2) if incentives and risk sharing arrangements are prohibited, hospital costs and utilization will rise. With each premium increase the number of uninsured grows. Current risk arrangements should be maintained to keep costs down.

5. The working group will continue its study and report back at the Financial Solvency Standards Board's April meeting.

V. Closing Remarks/Next Steps

1. The next Solvency Board meeting will be held on Tuesday, March 19, 2002 at the State Department of Consumer Affairs Building in Sacramento.
2. Following closing remarks, the meeting was adjourned.