

How the New California Department of Managed Health Care Regulations Affect Your Healthcare Practice

January 22, 2020

By Michael H. Cohen

The California Department of Managed Health Care's (DMHC) passed a new regulation, effective July 1, 2019 that expands the types of healthcare companies that must be licensed. The regulation is a response to failures of companies that contract with Knox-Keene licensees who provide health care services through subscription plans. The licenses, typically HMOs, provided service to subscribers through:

- Agreements with doctors, hospitals, and other health providers to accept a regular fee (often a monthly fee) to provide medical services to patients
- Agreements with subscribers to pay a monthly subscription/fee

The new licensee agreement will give the DMHC oversight over the financial stability of these healthcare companies (often called restricted licensees or risk bearing organization).

The History of Knox-Keene Act

The Knox-Keene Health Care Services Plan Act of 1975 (Knox-Keene) was passed to help protect consumers who enrolled in medical health care service plans. These plans, according to the Knox-Keene Act define these plans 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."

The main targets of the Knox-Keene Act were and are health maintenance organizations, more commonly called HMOs and other organizations that provide or arrange for health care services – in return for payment on a capitated basis.

Generally, the health care service plan company is required, under Knox-Keene, to obtain a license from the California Department of Managed Health Care (DHMC).

The reason Knox-Keene was enacted was to help protect against the possibility members of the HMO or other plans would be left without access to care if the health plan became insolvent and couldn't cover the cost of future healthcare services.

Capitation agreements

Capitation payments are agreed payment arrangements (contracts) between a health insurance company and a medical care

provider. The payments are paid to physicians, medical practices, clinics, and hospitals – generally on a per-patient or per capita basis. The payments are normally fixed, monthly payments calculated 12 months in advance – regardless of how many times the patient needs medical services. Payments usually reflect the subscriber's age and /or types of ailments. Rates can vary from one part of the country to another. Capitation plans generally identify which services must be provided to patients. There is a balance of risk between the insurance company and the medical provider. Typical medical services include:

- *“Preventive, diagnostic, and treatment services*
- *injections, immunizations, and medications administered in the office*
- *Outpatient laboratory tests done either in the office or at a designated laboratory*
- *Health education and counseling services performed in the office*
- *Routine vision and hearing screening”*

In simpler terms, a capitation plan is a per-member, per-month payment. The payments are made in advance, not after the services have been provided.

PACKAGING MEDICAL SERVICES – IS IT A LEGAL CONCIERGE ARRANGEMENT, OR AN ILLEGAL KICKBACK?

If you're a medical doctor, dentist, acupuncturist, chiropractor, or other licensed healthcare provider, and you offer your patients “9 sessions, get 1 free,” have you violated kickback laws?

Licensing requirements under Knox-Keene

Knox-Keene § 1349 provides that:

“It is unlawful for any person to engage in business as a plan in this state or to receive advance or periodic consideration in connection with a plan from or on behalf of persons in this state unless such person has first secured from the director a license, then in effect, as a plan or unless such person is exempted by the provisions of Section 1343 or a rule adopted thereunder. A person licensed pursuant to this chapter need not be licensed pursuant to the Insurance Code to operate a health care service plan or specialized health care service plan unless the plan is operated by an insurer, in which case the insurer shall also be licensed by the Insurance Commissioner.”

Generally, there are two types of plans that seek licenses under Knox-Keene:

- **Fully-licensed plans.** These plans enroll groups and individuals directly. They either provide or arrange to provide medical services to the members in exchange for a premium or subscription payment. Normally, the plan will provide a set of services such as primary care, inpatient hospital care, and other services.

Some licenses who provide just one basic health service such as mental health may obtain a specialized Knox-Keene license instead of a full license.

- **Restricted plans** are plans where a company contracts with a Knox-Keene licensee to provide or arrange for services to the members of the plan. Prior to the new regulation, restricted plans did not require a license. Now, as a result of the new DMHC regulations, restricted plans will require a license.

The 2005 DMHC regulation which expanded Knox-Keene licensing requirements

Historically, some independent physician associations (IPAs) and hospitals took part in restricted plans and/or global capitation agreements. The risk was passed from the insurance plan to the IPAs and hospitals who took part in these global capitation agreements. The health plan would create the arrangements to pay the providers a fixed monthly sum and assign a set of

patients to the providers. If the patient group remained healthy – meaning they didn't seek much use of the provider's medical services – the providers could make a nice profit. On the other hand, if the patient group used a lot of medical services, the providers could lose a lot of money and time treating the patients in this group.

This technique didn't work too well because it was hard for the hospitals and IPAs to analyze the risk factors. So, in 2005, the DMHC created regulations that required "Risk Bearing Organizations (RBOs)" that contracted with the licensed insurers to provide financial metrics to the DMHC – so the DHMC could determine the financial health of the RBOS – and in turn, help the hospitals and IPAs better assess their risks. The law did not require that the RBO obtain their own license. Without the requirement to obtain their own license, the DHMC could only direct the licensed health insurance plan – not the RBO.

The new DMHC regulation

A new regulation approved by the DHMHC expands the types of organizations that must obtain a Knox-Keene license. In essence, the new regulations will require that the RBOs and restricted plans will now need to obtain a license. The current requirement to obtain a full-service Knox-Keene license or a specialized Knox-Keene license is expanded to include many types of health companies including the RBOs, the IPAs, hospitals, and other health plans that engage in global risk.

The regulation becomes effective on July 1, 2019. Any health care organization that bears the financial risk of providing medical services to subscribers will need to review the new licensing requirements with an experienced California healthcare lawyer.

THE MANY WAYS YOUR NEW MEDICAL BUSINESS CAN GET INTO TROUBLE IF YOU DON'T CONSULT WITH AN EXPERIENCED HEALTHCARE LAWYER

Healthcare startup lawyers advise new medical business on FTC law, FDA law, marketing regulations, purchasing practices, nanotechnology, contract negotiation, and a range of business issues.

The new regulations are being phased in. Health insurance plan companies and the medical practices and hospitals that contract with them should review with their healthcare lawyer:

- The timing of the new regulations
- Which arrangements will require a license. Some payment arrangements may be exempted, for now, from the requirement to obtain a license.

Part of the focus of the new regulation, in addition to focusing on licensing requirements for restricted licensees, are arrangements with employers who self-insure without having a license.

The newest DHMC regulation expands the definition of "Prepaid or periodic charge" to include any entity/individual that contracts to assume the risk/costs of various types of hospital services, physician services, pharmacy services, and other identifiable medical services – whether in a fixed amount or a percentage of shared profits and losses. More formally a "prepaid or periodic charge" is defined as

"(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" (28 C.C.R. 1300.49 (a)(4)).

Other key definitions in the new regulation include:

“Global risk’ means the acceptance of a prepaid or periodic charge from or on behalf of enrollees in return for the assumption of both professional and institutional risk.”

“Restricted health care service plan’ means a person with a health care service plan license issued by the Department for the provision of, or the arranging, payment, or reimbursement for the provision of, health care services to subscribers or enrollees of another full service or specialized health care service plan under a contract or other arrangement whereby the person assumes both professional and institutional risk but does not directly market, solicit, or sell health care service plan contracts.”

The regulation adds teeth to the 2005 regulations by requiring that RBOs become licensed and thus subject to regulation by the DHMC under the Knox-Keene Act. The regulation will require these new licensees provide evidence of working capital and other financial measurements – and to show the entity/person is meeting the metrics they report. The regulations also govern the ability of the RBO to pay claims, provide medical care, and provide case management.

This means RBOs need to consult with experienced healthcare lawyers now. RBOs need to know if they are required to comply with the new regulation, when they must seek a license, and how they can obtain a license.

In some cases, exemptions may be available – mainly if the exemption would be in the best interests of the subscribers to these plans. For example, some hospitals and organization that participate in these capitation plans may be exempt if they are already regulated through a state or federal Medicare plan. HMOs and current licensees should also review if the organizations they work with need to be licensed.

In response to numerous failures of health care plans that contracted for services through periodic/subscription payments, the California Department of Managed Health Care’s (DMHC) passed a new rule. This rule means that many health care plans (whether through an employer or through an independent business) are now required to obtain a state license. The licensees will be governed by the Knox-Keene Act.

Plans that are covered by Knox-Keene must:

- Provide specific services and access to those services
- Comply with the Patient Protection and Affordable Care Act
- Create a utilization review process
- Create a dispute resolution process

Licensees may be required to provide financial reports and verifications to help insure their solvency.

Plans that aren’t covered by Knox-Keene may still be governed by other agencies and laws – both at the state and federal level. For example, the California Department of Insurance (DOI) regulates insurance plans. The US Department of Labor has regulatory authority over ERISA plans. Knox-Keene plans may also be governed by these additional agencies and regulations.

Contact Cohen Healthcare Law Group, PC to assess whether the new DHMC regulations affect your medical practice or medical company.

Contact our healthcare law and FDA attorneys for legal advice relevant to your healthcare venture.