This Document will describe the issues raised by HealthCare Partners business model, particularly the fact that they do not have a Knox-Keene license despite the fact that they appear to take full risk.

**THE PURPOSE OF THE KNOX-KEENE ACT:**

Health and Safety Code section 1342 described the intent of legislature in creating the Knox-Keene Act. It includes, among other provisions, the following:

(d) Helping to ensure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers; (in other words, promoting the managed care model).

(e) Promoting effective representation of the interests of subscribers and enrollees.

(f) Ensuring the financial stability thereof by means of proper regulatory procedures.

(g) Ensuring that subscribers and enrollees receive available and accessible health and medical services rendered in a manner providing continuity of care.

(h) Ensuring that subscribers and enrollees have their grievances expeditiously and thoroughly reviewed by the department.

**THE LICENSURE REQUIREMENT:**

What type of entity is required to obtain a Knox-Keene license? Simply put, any entity that takes global risk, meaning that they are at financial risk for the professional and institutional claims incurred by their membership. This would include all health plans that sell an insurance product, but would also include physicians groups that accept global risk.

The Knox-Keene Act itself could arguably be read to mean that any entity that takes any type of financial risk for patient care must be licensed. Section 1349 provides: “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 . . . .”

It has long been understood, however, that an entity that only takes financial risk that is within the scope of its license is impliedly exempted from the Knox-Keene licensure requirements, and instead is only regulated by the Department of Managed Health Care as a risk bearing organization. See, Overview of Risk Sharing Arrangements, Prepared for the Financial Solvency Standards Board Meeting, January 29, 2002, (the
“FFSB Memo”), at pp. 2-3. Thus, a physician may be paid capitation to provide care for his or her patients, and a physicians’ organization may take risk for the professional services provided to its patients (since all those services are within the scope of the physicians’ license).

Unlike partial risk shifting, in the “full risk” or “global risk” situation, the plan shifts the risk for both professional and institutional care to another entity. If the plan shifts the professional risk to physicians and the institutional risk to hospitals, no license is needed because each is operating within the scope of their license. When, however, the institutional risk is shifted to physicians, who do not have hospital licenses, the physicians’ group must have a Knox-Keene license to accept the risk. FSSB Memo at p. 5.

In short, as stated in the FFSB memo at page 11, “whenever a physician organization is placed at financial risk for ‘institutional’ health care services, it has wandered in the area of global capitation, which is a prohibited activity . . . .”

**HEALTHCARE PARTNERS IS TAKING GLOBAL RISK:**

That HCP is taking global risk is illustrated both by the statements it has made, as well as by the description of its business model in the prospectus prepared for the HCP shareholders prior to the merger with DaVita.

**Healthcare Partners Has Stated It Is Accepting Global Risk:**

- On May 21, 2012 when announcing the merger with DaVita, Bob Margolis, HCP’s CEO said in a conference call announcing the merger that “We have for decades now been taking the clinical and economic responsibility for the populations of patients in commercial, in Medicaid and Medicare. And we do it on what’s called a globally budgeted or capitated basis.”
- In early November at the American Society of Nephrology meeting Allan Nissenson, the chief medical officer of Davita, presenting with Bill Chin, the chief medical officer of HCP, told the crowd that Davita had joined with HCP because HCP “were taking full capitated risk.”
- In an Atlantic Magazine article dated February 7, 2013, it states: “Unlike the majority of hospitals and doctors who are paid a fee for each office visit, surgery, or hospital day the patient uses, HealthCare Partners is paid a flat monthly fee for each Medicare recipient, and is then responsible for providing -- or paying for -- all health services for that patient including hospitalization, surgery, chemotherapy, and annual checkups.”
- In a January 2012 case study by the Commonwealth Fund, Bob Margolis, the CEO of HCP, was quoted as saying that one needed to “get the full capitation, global capitation for the full risk across the entire spectrum of care.”
HealthCare Partners’ Merger Prospectus Describes How It Takes Global Risk:

In the prospectus, HCP describes its business model, which clearly describes how, by any common definition, HCP is “at risk” for the institutional care provided to its members. It is thus taking “global risk.”

First, HCP explains its business model, and how it accounts for its revenue and expenses. Technically, HCP cannot admit that it is at risk for institutional care, but also wants to assure that it can claim credit for the full amount of the revenue it manages. Thus, when you look at the revenue line, it only includes the profit on institutional care. But, it has also created a new revenue line it calls “total care dollars under management,” which is a much higher number and includes all institutional revenue associated with its managed care population. Prospectus, p. 27.

Then, HCP explains that “under most of HCP’s agreements with health plans, HCP assumes some or all of the risk that the cost of providing services will exceed its compensation.” Specifically, its describes how in California it enters into agreements with hospitals where it is entitled to keep “up to 100% of the amount by which the hospital capitation revenue exceeds hospital expenses . . . .” Prospectus p. 60.

The prospectus continues, stating that”

“[t]o the extent that members require more care than is anticipated, aggregate PMPM payments may be insufficient to cover the costs associated with treatment. If medical expenses exceed estimates, except in very limited circumstances, HCP will not be able to increase the PMPM fee received under these risk agreements during their then-current terms.

“If HCP or its affiliated physician groups enter into capitation contracts with unfavorable economic terms, or a capitation contract is amended to include unfavorable terms, HCP could, directly or indirectly through its contracts with HCPAMG, suffer losses with respect to such contract. Since HCP does not negotiate with CMS or any health plan regarding the benefits to be provided under their Medicare Advantage or other managed care plans, HCP often has just a few months to familiarize itself with each new annual package of benefits it is expected to offer.” Prospectus, p. 60.

HEALTHCARE PARTNERS IS AWARE OF THE RISKS IT IS TAKING BY FAILING TO GET A LICENSE, AND AWARE THAT IT COULD BE SUBJECT TO CIVIL AND CRIMINAL PENALTIES:

In perhaps the most important admissions in the entire document, on pages 175-176 HCP states the following when discussing the risks inherent in its model:
The DMHC interprets the Knox-Keene Act to apply to both HCSPs (health care service plans) and downstream contracting entities, including provider groups, that enter into “global risk contracts” with licensed HCSPs. A “global risk contract” is a health care services contract in which a downstream contracting entity agrees to provide both professional (e.g., medical group) services and institutional (e.g., hospital) services subject to an at-risk or capitated reimbursement methodology. According to DMHC, entities that accept global risk must obtain a limited Knox-Keene license.”

“Under a limited Knox-Keene license, entities may enter into global risk contracts with other licensed HCSPs. Holders of limited licenses must comply with the same financial requirements as HCSPs with full licenses, including demonstrating specific levels of TNE, but are granted waivers from meeting marketing and other terms of full Knox-Keene licensure. The consequences of operating without a license include civil penalties, criminal penalties and the issuance of cease and desist orders.”

“HCP does not hold a limited Knox-Keene license. Instead of operating under such a license which would allow HCP to directly enter risk contracts with HCSPs for the provision of both professional and institutional services, HCP utilizes arrangements with hospital and its affiliated physician organizations. If (i) DMHC were to determine that HCP has been inappropriately taking global risk for institutional and professional services as a result of its various hospital and physician arrangements without having a limited Knox-Keene license or (ii) the California Board of Medicine were to conclude that the current HCP physician arrangements present a violation of the corporate practice of medicine, HCP may be required to obtain a limited Knox-Keene license to resolve such violations and HCP could be subject to civil and criminal penalties. Alternatively, HCP might voluntarily elect to obtain a limited Knox-Keene license for various reasons including to permit it to contract directly with HCSPs, to simplify its current contractual and financial structure and to facilitate expansion into new markets. If HCP were to obtain a limited Knox-Keene license, one of the primary impacts would be the TNE requirements described above.”

HEALTHCARE PARTNERS DOES NOT OBTAIN A LICENSE SPECIFICALLY SO IT CAN AVOID REGULATORY OVERSIGHT:

Tellingly, HCP admits that it does not get a Knox-Keene license specifically so it can avoid regulatory oversight, and so it does not need to meet the financial requirements that a licensee must meet:

“Although obtaining such a limited Knox-Keene license would ameliorate risks under the Knox-Keene Act and California’s corporate practice of medicine prohibition, there are disadvantages associated with obtaining such a license. These disadvantages include: (1) regulatory oversight of operations, (2) the need to seek approval for all
material business changes, (3) significant requirements to maintain certain TNE levels, and (4) other operating limitations imposed by the Knox-Keene Act and its regulations.” Prospectus, p. 176.

**SUMMING UP:**

In short, HCP is taking full risk (what else can it be called when it is responsible for any losses incurred on the institutional care provided to its members), is therefore required to have a Knox-Keene license. But, HCP does not have the required license. And, it does not have the required license, not because it could not get one if it wished, but solely so that it can avoid the regulatory oversight to which is should be subjected, and so that it can avoid the financial requirements that licensees must meet.

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1 “In California, as a result of its managed care administrative services agreement with hospitals, HCP does not assume the direct financial risk for institutional (hospital) services, but is responsible for managing the care dollars associated with both the professional (physician) and institutional services being provided for the per-member per-month, or PMPM, fee attributable to both professional and institutional services. In those cases, HCP recognizes the surplus of institutional revenue less institutional expense as HCP revenue. In addition to revenues recognized for financial reporting purposes, HCP measures its total care dollars under management, which includes the PMPM fee payable to third parties for institutional (hospital) services where HCP manages the care provided to its members by the hospitals and other institutions, which are not included in GAAP revenues. HCP uses total care dollars under management as a supplement to GAAP revenues as it allows HCP to measure profit margins on a comparable basis across both the global capitation model (where HCP assumes the full financial risk for all services, including institutional services) and the risk sharing models (where HCP operates under managed care administrative services agreements where HCP does not assume the full risk). HCP believes that presenting amounts in this manner is useful because it presents its operations on a unified basis without the complication caused by models that HCP has adopted in its California market as a result of various regulations related to the assumption of institutional risk. Total care dollars under management is not a measure of financial performance computed in accordance with GAAP and should not be considered in isolation or as a substitute for revenues calculated in accordance with GAAP. Total care dollars under management includes PMPM payments to third parties that are not recorded in HCP’s accounting records and have not been reviewed and are not otherwise subject to procedures by HCP’s independent auditors. For a reconciliation of total care dollars under management to HCP’s medical revenues, see “Management’s Discussion and Analysis of Financial Conditions and Results of Operations—Total Care Dollars Under Management.” Prospectus, page 27.
The following is a more detailed description of the risk share model taken from the Prospectus. “Risk-Share Model. In California, HCP utilizes a capitation model in several different forms. While there are variations specific to each arrangement, HCP generally contracts with health plans to receive a PMPM fee for professional (physician) services and assumes the financial responsibility for professional services only. In some cases, the health plans separately enter into capitation contracts with third parties (typically hospitals) who receive directly a portion of the PMPM fee and assume contractual financial responsibility for institutional (hospital) services. In other cases, the health plan does not pay any portion of the PMPM fee to the hospital, but rather simply administers claims for hospital expenses itself. In both cases, HCP is responsible for managing the care dollars associated with both the professional and institutional services provided for the PMPM fee, but in the case of institutional services and as a result of its managed care-related administrative services agreements with hospitals, HCP recognizes the surplus of institutional revenues less institutional expense as HCP revenues.” Prospectus, p. 168.