Published on *The National Law Review* https://natlawreview.com

Risk Bearing Entity Requirements: An Introduction

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Providers and provider organizations are increasingly contracting with payors to manage specific patient pools and diseases on a risk basis. They are taking new and increasing financial risk to better align with payors' interests of increased quality and decreased cost. State regulators are paying increasing attention to these relationships as they become both more common and complex.

This blog series will dive into state oversight for providers and provider organizations engaged in financial risk (risk bearing entities or RBEs) in the sample states of California, Georgia, Massachusetts, New Jersey, and New York.

State regulation of RBEs can extend to providers and provider organizations contracting for some level of financial risk with a payor. Payors can be individual and group commercial health plans, employer sponsored health plans, Medicare Advantage, Medicaid Managed Care, or other government health plans. Risk contracting includes a wide range of different payment models, each of which holds the RBE financially responsible at some level for care delivered to its patients. These models include:

- Upside Risk Arrangements: providers can earn additional money or benefit from savings if they meet or exceed agreed upon quality and other metrics (e.g., high patient satisfaction scores or low readmission rates).
- Downside Risk Arrangements: providers may be financially penalized if they perform poorly on the agreed upon quality and other metrics (e.g., high rate of hospital-acquired infections or readmission rates).
- Two-Sided Risk Arrangements: providers have the opportunity to financially gain or lose based on their performance.
- Capitated Arrangements: providers receive lump sum payments in exchange for taking financial responsibility for identified patients, potentially on a limited or global basis.

RBEs come in a number of different organizational forms and state regulation is generally (but not

always) agnostic as to an RBE's structure. Some of the most common structures include:

- Accountable Care Organizations (ACOs)
- Clinically Integrated Networks (CINs)
- Independent Physician Associations (IPAs)

By way of example, ACOs can include health care organizations that convene participating hospitals, physician groups and several other providers who work collaboratively to lower health care costs and improve quality for common patient populations. ACO providers join an ACO pursuant to a participating provider contract, which allows the ACO to provide oversight, management and care coordination functions for and on behalf of its providers.

The Centers for Medicare & Medicaid Services (CMS) has developed two prominent shared savings demonstration models involving ACO structures that allow health care providers to explore or expand their transition to value-based care models – the Medicare Shared Saving Program (MSSP) and the Realizing Equity, Access, and Community Health (REACH) Model. Both models orient around Medicare fee-for-service beneficiary patient populations and offer up-side and/or down-side risk sharing arrangements.

By engaging in financial risk, RBEs and their providers are economically incentivized to take ownership of the patient lives allocated to them and perform well on quality and other reporting metrics. While this can be desirable for patients, providers and payors alike, providers and provider organizations need to be mindful of when and how they may be regulated as they enter into risk-based payment arrangements. State RBE requirements generally focus on registration, financial strength and the review and monitoring of risk arrangements.

This blog series will aid providers and provider organizations in identifying when they are subject to RBE requirements in the sample states of California, Georgia, Massachusetts, New Jersey, and New York; and outline what providers and provider organizations need to know about getting and staying in compliance with these requirements.

National Law Review, Volume XIV, Number 323