Golden State **Guidepost**

A preview of operational, financial, and regulatory dilemmas

By Cindy Ehnes

California's delegated model—under which organized groups of physicians accept responsibility for managing the professional services care of HMO enrollees—arguably has been California's preferred system for delivering health care since the early 1980s. Delegated independent practice associations (IPAs) and medical groups in California provide valuable healthcare services to millions of Medi-Cal Managed Care, Medicare Advantage, and commercial health maintenance organization (HMO) members. More than 200 integrated medical groups and IPAs are paid through a fixed per-member, per-month (PMPM) fee, called "capitation." These pioneering providers have practiced population health management before it gained industry currency and have for decades linked outcomes-based payment to incentivize provider innovation.

Capitation and delegation of accountability for health services delivery, utilization management, and claims payment began in California in the 1980s. Capitated and delegated medical groups and IPAs flourished for a number of years, then, in the late 1990s, experienced several spectacular, high-profile failures of risk-bearing large medical groups. Risk-bearing groups realigned under a tightened regulatory regime in the early 2000s, and most observers believe that the delegated model has overall been a success in an integrated and regulated environment.

HMOs using delegation have better served Californians than the fee-for-service model. In the latest Integrated Healthcare Association *California Regional Health Care Cost and Quality Atlas*[1], HMO products significantly outperformed PPO products on cost and clinical quality—by an average of 14 percentage points across 10 measures of preventive, acute, and chronic care reported for commercial insurance for 2015.

Risk-bearing medical groups and IPAs turn to captive or separate management services organizations (MSOs) to provide arrangements for delivering high-quality care services. The recent high-profile collapse of one of the nation's prominent risk-bearing medical groups based in Los Angeles and its affiliated MSO highlights potential operational, financial, and regulatory dilemmas that must be carefully managed in the relationship between an MSO and one or more medical groups. In 2017, the organization had more than 6,000 physicians and 600,000 capitated enrollees statewide. Ninety percent of its patients were Medi-Cal capitated managed care members served by primary care physicians (PCPs) under contracts with nine health plans.

Here, we share our thoughts and examine three issues of concern:

- The need for health plan oversight
- How to enable risk-bearing medical groups to successfully govern their MSOs
- Policy concerns related to offering "narrow networks" based on, among other factors, economic profiling

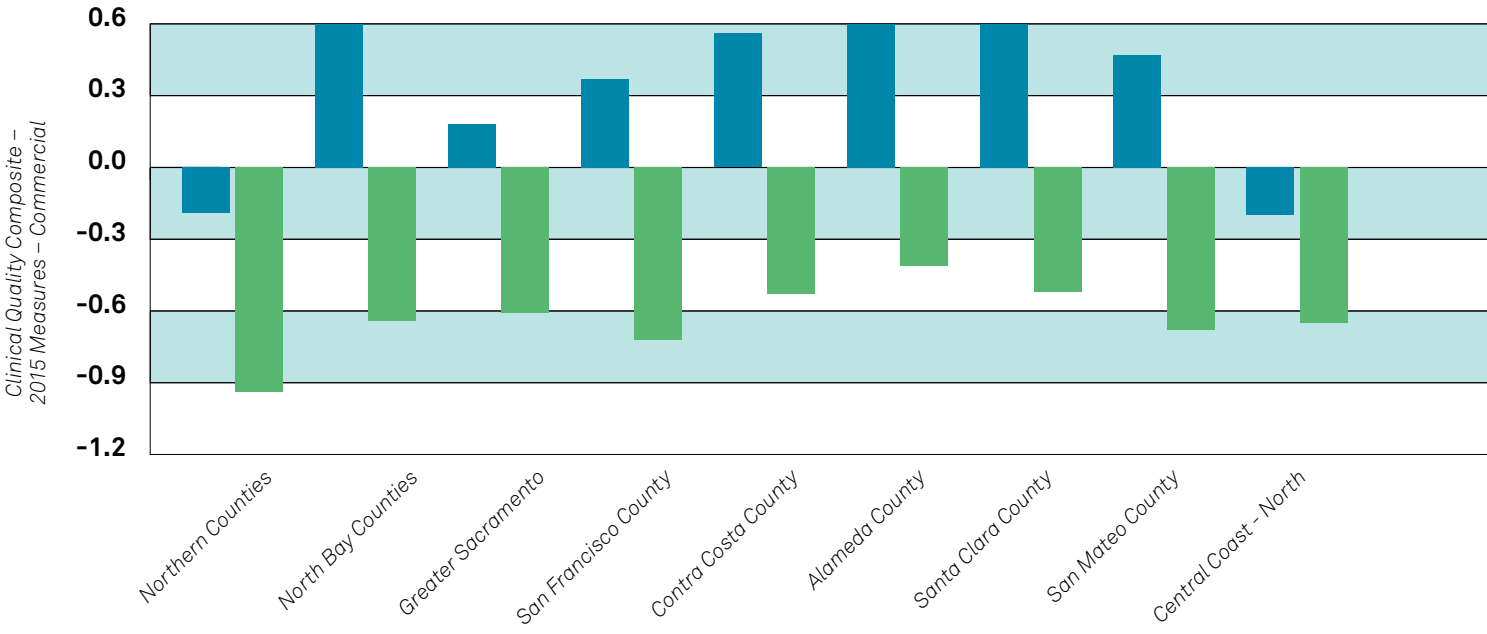
Health Plan Oversight

There is much speculation over whether and to what extent California's regulators will address delegation oversight by health plans, spurred by the experience of the aforementioned failed prominent group and its MSO.

Are new regulatory oversight standards necessary? As our regulators contemplate additional bold actions, we must consider that increasing oversight increases cost and shrinks the already tight margins of Medi-Cal managed care dollars going to providers. Enforcing existing requirements is likely a preferred starting point.

Health plans bear a compliance responsibility when contracting with downstream providers. In California and many other states, health plans bear the ultimate responsibility to safeguard care standards and monitor the claims payment capability and financial solvency of risk-bearing medical groups. The Centers for Medicare & Medicaid Services (CMS)

Comparing Commercial HMO and PPO Products



and California Department of Health Care Services (DHCS) have made it increasingly clear that plans are ultimately accountable for fulfilling the terms and conditions of their contracts and are responsible for the actions and failures of their downstream providers to comply with these requirements.

This oversight and accountability for healthcare delivery and compliance can attenuate when multiple plans interact with multiple IPAs with MSO relationships. Therefore, it is essential to strengthen expectations for these MSOs—with as few additional system costs as possible. Health plans must take an active role in MSO oversight and possibly other key vendor relationships. Additionally, health plans must support providers with access to and transparency into claims data and other information necessary for member management.

Joint audits by DHCS and California Department of Managed Health Care (DMHC) for contractual and regulatory compliance have increased over time and are expected to continue. Allowing insurers to conduct regular joint audits of IPAs and MSOs may save valuable time and financial resources, as well as make it easy to identify risks by avoiding compartmentalization.

Board Governance

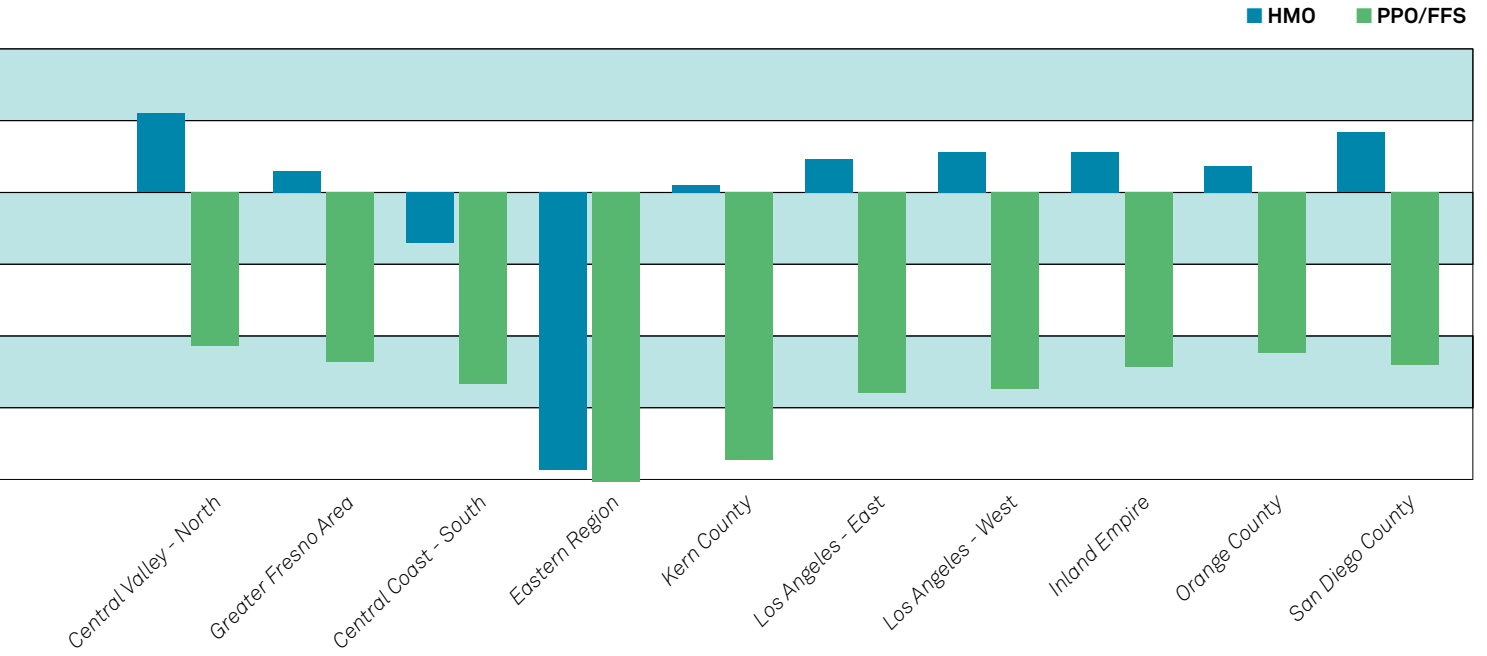
The medical group MSO experience mentioned above also raises a valid question about whether IPA and medical group executives and directors have the day-to-day authority and access to information required to detect and act affirmatively against malfeasance by a contracted MSO. This requires skilled governance by medical groups and IPAs—staying out of day-to-day operations, yet having sufficient insight into the organization's management.

In large provider organizations, the board of directors has audit and finance subcommittees in addition to organizational compliance and internal audit functions. On a regular basis, audit and finance committees should review internal audit results and determine what should be raised for discussion with the full board. If no internal audit function exists within an organization, an external auditor should conduct internal audit functions and projects. A compliance officer with supporting staff should review policies, reports, audit findings, and all other issues with the audit and finance committees and the full board.

Small physician groups that lack requisite governance skills, resources, or competencies should recruit independent physician board members who have the skills or knowledge to ensure they can act as a true check on MSO operations. Most importantly, the compliance department/officer should create a hotline for any employee who becomes aware of compliance issues. These compliance functions, including the hotline, can also be outsourced.

Economic Profiling, Narrow Networks

Of all the issues arising from the downfall experience of this prominent medical group and its MSO, policy concerns related to "economic profiling" cited in the DMHC order is causing "heart palpitations" in the California delegated model and resounding across other states using a Medicaid Managed Care model. Forbidding a health plan to do further business with an IPA based on the health plan's failure to file a report on how it or the IPA is using "economic factors" to limit utilization by high-cost providers requires that regulators further articulate stakeholder engagement and policy.



Source: The California Regional Health Care Cost & Quality Atlas

While riled consumer advocates suggest that every patient should have the right to go to any doctor regardless of cost, selective networks are integral to Medicaid managed health care because everyone in the Medi-Cal managed care system lives on a budget. The state pays premiums to the health plan on a PMPM basis. The health plan pays the IPA a capitation payment (generally a portion of the premium) on a similar PMPM basis. Under a capitated model, that represents all the money available to care for the patient.

For example, Covered California, the state's healthcare exchange with products approved by the DMHC, is an "active purchaser" that openly distinguishes its product prices based on the relative cost of provider networks. Otherwise, products must offer the same essential benefits. Further, preferred provider organization (PPO) products regulated by the DMHC offer tiered networks based on economic considerations.

Therefore, the outstanding question is, will DMHC simply require a compliant filing, or will it "unmanage" managed care by forbidding provider pricing as a factor in narrowing network options? Stakeholder engagement, regulatory predictability, and reasonable regulations are essential underpinnings to balance access to the best physicians and hospitals with the regrettable reality of cost.

The history of the DMHC warrants optimism that balanced guidance will be forthcoming.

Tweaks, Not Overhaul

While the need for high scrutiny and strong accountability of delegated providers and MSOs may be highlighted by this collapse, the alleged wrongdoing of one medical group should not overshadow the large-scale success of California's delegated model. States are looking to the success and stability of the California delegated system for "rules of the road" as they increasingly establish budget-driven, delegated, and Medicaid responsibilities to managed healthcare plans and their capitated provider partners. California has outlined a structure for accountability that may need tweaking but not overhaul. Our state should continue to provide the exemplar for fostering safe and accountable care that shifts dollars from health plans to front-line physicians. GPJ

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References

1. Integrated Healthcare Association. 2018. *In Search of Value: How Well Do Commercial HMOs and PPOs Deliver? Atlas 2 Key Findings*. When combining performance across the 10 clinical quality measures, the study noted that HMO clinical quality was above the statewide average for 14 of the 19 regions, while PPO clinical quality performance was below the statewide average in all 19 regions. Of further mention in the study: In 2015, HMO products delivered 22% higher clinical quality and 9% lower costs than PPO products when member cost sharing is included. PPO members paid, on average, $769 more out of pocket for care in 2015 than HMO members.