COPE HEALTH SOLUTIONS

Call to Leadership: The California Delegated Model at Risk

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Libertarians, and others frustrated with the costs and strictures of regulation, may express the view that regulation of the insurance industry is often burdensome and unnecessary. Without addressing the global topic, there is a solid argument that good regulation serves the public interest through supporting ongoing confidence in the insurance market in which the public must participate and on which it must rely. Regulation in health care and health insurance ensures consumer protection, market certainty and the stability[1] of the industry.

For more than 40 years, California health care has embraced the policy of moving health care dollars closer to the actual providers of care in the form of capitation (or pre-paid per member per month) payments. This creates the risk that the dollars paid to the capitated provider may not be adequate for all the necessary services. A system of laws and regulations have developed over time to ensure that patient service delivery in this capitated, delegated[2] delivery model meets quality care standards and that the provider group's finances are stable.

However, despite the large-scale success of this model with most risk-bearing organizations largely financially compliant[3], recent state regulatory decisions have engendered great uncertainty and instability in the California capitated, delegated model. This case of regulatory overreaction comes at the very time when credible evidence supports the superiority of the capitated, delegated model in cost, coordination of services and quality over fee-for-service payment models. For several years, The Integrated Healthcare Association has tracked more than 200 provider organizations offering services under HMO contracts and has conclusively demonstrated that HMOs in California using delegated providers are delivering higher quality at lower cost than PPOs.[4]

The collapse in December 2017 of one of the largest Management Services Organizations (MSOs) in California has revealed concerns in oversight of delegated entities that arguably require appropriate regulatory response from the California Department of Managed Health Care (DMHC). The failure in January 2018 of the Southern California SynerMed MSO and its founding medical group, Employee Health Systems (EHS), was a calamity from virtually every angle. A whistleblower complaint alleged deliberate, orchestrated fraud related to specialty referrals, grievance handling and systematic overrides of dates to create compliant records.[5] The strong appearance was that the largest medical group, EHS, that contracted SynerMed, had failed to exercise any meaningful oversight of its wayward MSO.

The California Department of Health Care Services (DHCS) stepped in and imposed a Corrective Action Plan, whose terms SynerMed arguably met. Then, in response to a second whistleblower complaint, the DMHC stepped in, despite its tangential oversight role over medical groups and MSOs, and rather than requiring its own customary corrective action plan[6], ordered all plans to terminate their contracts with EHS and transfer 600,000 patients, 90 percent of who are California Managed Medicaid ("MediCal") patients. This action effectively shut down both SynerMed and EHS. The SynerMed failure resulted in a national black eye for delegation and revealed some fundamental gaps in health plan and medical group oversight of MSOs.

The potential industry problems implied by the SynerMed/EHS takedown are real:

- Inadequate compliance oversight of risk-bearing IPAs and medical groups by contracting health plans
- Alleged denial of medically necessary access to higher cost medical specialists
- Lack of proper IPA oversight over contracted MSOs, which are essential partners for especially small providers but potentially may lack accountability and proper oversight
- Questions as to whether delegated providers are improving their increasingly important quality scores and providing value for their share of the premium dollar
- Issues as to how much of the State's skinny MediCal premium dollar is actually getting into the hands of the actual providers of care

High quality health care is only getting more complex as expectations of health plans are redefining efficient and effective care to embrace "whole person care," addressing social determinants of health and higher quality of care[7]. This concept adds complexity and necessitates coordination of care and contracting with community-based providers. These essential community relationships are local and are best coordinated with treating and risk-bearing providers, who manage cost and are accountable for quality versus a distant health plan.

The State MediCal system, as well as health plans and provider groups, need these third parties because those on-the-ground, culturally competent, community based relationships are pivotal to whole person care. Medical groups and health systems taking capitation, particularly in MediCal, now face greater complexity and increasingly may rely on contracted third party MSOs for managing risk contracting, coordinating care and other administrative services. These third party entities must adhere to all laws, regulations and contractual provisions as the capitated, delegated provider group or IPA and health plan.

The SynerMed collapse shined a bright light on these third party entities and on the need to strengthen their accountability and oversight. However, both DMHC and DHCS have approached these issues in such a way as to create uneven enforcement, uncertainty, and unnecessary administrative costs for providers. This approach risks undermining confidence and placing an increasing financial and administrative strain on the largest delegated system in the country, rather than serving as an opportunity to help capitated groups to improve. Undermining the capitated, delegated model may have unintended consequences for the MediCal system, in which contracted managed care organizations are deeply dependent on capitated, delegated payment models to provide health care for approximately 10.5 million MediCal members.[8]

An appropriate regulatory response to these legitimate concerns regarding oversight and value of the delegated model would bear the imprint of seven characteristics:

- Necessity: It should respond to a clear issue or market failure and address bad behavior
- Transparency: Regulators should not hide behind opaque bureaucratic walls
- Due Process: Broad Stakeholder inclusion and process are essential to credible regulation
- Predictability: The regulation should create more certainty in the relevant market
- Proportionality: Regulation should strive to impose the least burden possible to solve a problem
- Level Playing Field: Rules must apply equivalently to all relevant stakeholders
- Measurable and Measured Effectiveness: Regulations without meaningful and measurable enforcement of the rules undermines their legitimacy.

Necessity: Arguably, refinement of regulation is called for as accountability moves from a directly regulated health plan to delegated provider to MSOs. The complexity of relationships can make it difficult to know which party is doing what and with what degree of compliance. Further, while profiling of contracted primary and specialty providers is integral to narrow networks and increasingly associated with highest value care, such a selection process must ensure access to high quality providers, not just the cheapest. Striking the balance on ensuring patient access to medically necessary services requires

refined, legally discriminatory referral processes based on transparent criteria.

Transparency: Agencies that are addressing broad industry issues should be equally accessible to all affected parties. The DMHC, working closely with DHCS, launched an investigation that is still ongoing after one year, without publicly revealing the findings that would buttress its rationale for its termination order and provide guidance on what policies and procedures must be followed to engage in "economic profiling"[9] of providers. No health plan has been sanctioned for their own provider selection policies and the DMHC has met regularly and exclusively over many months with health plans without scheduling similar ongoing communication opportunities for input from health plans' contracted providers. DMHC has now, after one year, reached out to delegated groups for input on its draft "All Plan Letter." As the DMHC plans to expand its direct oversight of these providers and MSOs, transparency requires open communication and sharing substantiated findings and desired remedies.

Due Process: Every party affected by regulation should have the same lawful access to help shape effective and enforceable regulations. Historically, DMHC staff has communicated in a two-way fashion with members of the public, affected industry and consumer stakeholders and answered questions informally about the intent and meaning of proposed regulation. Such communications did not make commitments to a particular course but addressed ambiguities and confusions that resulted in more focused formal stakeholder comments. Regulations issued with insufficient stakeholder input on equal terms with all highly affected entities lacks credibility.

Predictability: California health plans are under intense pressure to strengthen oversight and audits of their delegated providers and MSOs. Certain MSOs appear to be facing multiple audits each week, while others are seeing no change in oversight. While targeted enforcement may be appropriate, this unpredictability in scheduling, scope and sampling, significantly increases administrative burden and costs and risks depletion of dollars to cover required medical care. Further, basing a high profile enforcement action on allegations of improper economic profiling, while failing to define the term over the last year, leaves the definition in the capricious realm of "we'll know it when we see it". A promised industry guidance will better articulate the lawful boundaries of a practice used by every health plan and insurance carrier in narrowing networks to better manage the high costs of health care.

Proportionality: Regulation should strive to impose the least burden possible to solve a problem. This requires a deep understanding of the issues. This is the moment when convening stakeholders is most important because what has been exposed is not simply one or a few "bad boys," but rather an area where the industry has collectively failed to grasp the intricacies of delegated providers' downstream partners. The DMHC has traditionally held plans accountable to monitor the behavior of their delegates; it now plans to expand its direct oversight to include regulatory oversight of all entities that are delegated for Knox Keene Act-regulated functions, mostly MSOs, not just RBOs. With this substantial expansion of authority, the case for communication and coordination becomes paramount. It is unclear that burdening all the delegated providers, particularly smaller entities, and their MSOs with uncoordinated and expensive audits is proportional to the actual problem.

Level Playing Field: Rules must apply equivalently to all relevant stakeholders. Regulation should strive to preserve a level playing field among differently sized provider organizations actively engaged in cost, quality and access objectives. DMHC regulatory tweaks could inadvertently favor or disfavor certain kinds of providers or payors. As it currently stands, the approach taken by DMHC and DHCS ironically hits ethnic providers harder than others because ethnic providers are more generally dedicated to serving MediCal patients. Such inadvertent favoritism could drive smaller and cultural provider organizations from the market and thus reduce competition, increase costs or reduce quality of, and access to, culturally competent care.

Measurable and Measured Effectiveness: Regulations without meaningful and measurable enforcement of the rules undermines their legitimacy. Compliance audits of

delegated providers lack uniformity. While joint audits may not be appropriate, common audit standards and a clear definition of impermissible "economic profiling," will allow compliance pre-audits to be conducted internally by delegated providers and external audits by contracted health plans. The state should consider creating a deemed status for a certified delegation oversight audit organization that health plans can use to meet their oversight obligations, and thus increase the level of intense audit scrutiny but reduce the administrative burden by having fewer audits. Using common standards will allow credible measurability of improving care and compliance.

As the saying goes: "Bad cases make bad law." SynerMed has literally changed the California health industry and raised the question whether California can lead the nation on delegated risk and responsibility if it cannot ensure access and compliance. As regulators contemplate tightening oversight of delegated IPA and medical groups' business, measured action is called for, because when delegation works, it is a superior method to traditional fee-for-service medicine. Regulators should strive to cure, not kill, the delegated model in California.

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Endnotes

[1] The insurance industry often promotes a demonstrably false myth that regulation and competition are incompatible. Regulation protects against insurer insolvency, fosters fair competition and availability of insurance to the broadest public.

[2] In California, Health Maintenance Organizations (HMOs) pass most of the financial risk for the costs of medical care through fixed per member, per month payments and delegate most of the responsibility for managing care to these physician-controlled organizations.

[3] http://dmhc.ca.gov/Portals/0/Docs/DO/FSSB%20October%202018/Agenda%20Item%209_Provider%20Solvency%20Quarterly%20Update.pdf.

[4] https://atlas.iha.org

[5] California Department of Managed Health Care, Order to Cease and Desist, December 26, 2017.

[6] See e.g. the Department'ss recent approval of CVS' acquisition of Aetna Health Plan, which Order noted low OPA report card scores on "Getting Care Easily" and outstanding persistent issues related to grievance handling, which resulted in a mere requirement to improve those scores within twelve months. California Department of Managed Health Care, Order, November 15, 2018. DMHC Approves CVS's Acquisition of Aetna

[7] It is noteworthy that SynerMed was successfully addressing these complex care issues in its Los Angeles Downtown Complex Care Clinic (DC3) clinic was providing personalized, coordinated care to its Medicare and Medicaid patients at the time of its shutdown.

[8] https://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCEnrollRptSept2018.pdf

[9] California Health & Safety Code 1367.02 requires, for purposes of public disclosure, every health care service plan must file with the department a description of any policies and procedures related to economic profiling of a particular physician, etc. based in whole or part the economic costs or utilization of medical services.