COPE HEALTH SOLUTIONS

California Delegated IPAs and Medical Groups: Operational, Financial and Regulatory Dilemmas

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Delegated IPAs and medical groups in California provide valuable health care services to millions of Medi-Cal Managed Care, Medicare Advantage and Commercial Health Maintenance Organization (HMO) members. These “pioneer” providers practiced population health management before it gained industry currency and have utilized outcomes-based payment to incentivize provider innovation for decades.

Risk-bearing medical groups and IPAs turn to captive or separate Management Services Organizations (MSOs) to provide many of the functions to arrange for the delivery of high-quality care services. The recent high profile collapse of one of the nation’s more prominent risk-bearing medical group and its affiliated MSO highlights a number of potential operational, financial and regulatory dilemmas that must be carefully managed in the relationship between an MSO and one or more medical groups.

Here we share our thoughts and examine three issues of concern: (1) the need for health plan oversight, (2) how to enable successful governance between a risk-bearing medical group and their MSOs and (3) policy concerns related to offering “narrow networks” based on, among other factors, economic profiling.

Health Plan Oversight

There has been much speculation around whether and to what extent California’s regulators will address delegation oversight by health plans, spurred on by the experience of the prominent group and its MSO. However, are new regulatory oversight standards necessary? As regulators contemplate additional, new bold actions, it is imperative to consider that increasing oversight increases cost and shrinks the already tight margins of the Medi-Cal managed care dollar going to providers. Enforcement of existing requirements is likely a better starting place.

Health plans bear a compliance responsibility when contracting with downstream providers. In California and in many states, the health plans bear the ultimate responsibility to safeguard the care standards and monitor the claims payment capability and financial solvency of risk-bearing medical groups. The Centers for Medicaid and Medicare Services (CMS) and California Department of Healthcare Services (DHCS) have also made it increasingly clear that plans are ultimately accountable for fulfilling the terms and conditions of their contracts and are held responsible for the actions and failures of their downstream providers to comply with these requirements.

This oversight and accountability for health care delivery and compliance can become attenuated when multiple plans interact with multiple IPAs with MSO relationships. Therefore, it is essential to strengthen expectations for these MSOs, but with as few additional system costs as possible. Health plans must take a more active role in better oversight of MSOs, and possibly other key vendor relationships. Additionally, health plans must better 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. Perhaps allowing insurers to conduct regular joint audits of IPAs and MSOs will save valuable time and financial resources, as well as making it easier to identify risks by avoiding compartmentalization.

Board Governance

The experience of the medical group and its MSO discussed here 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 to act affirmatively against malfeasance by a contracted MSO. This requires a skillful approach to governance by medical groups and IPAs – staying out of day-to-day operations but having sufficient insight into the management of the organization.

In large provider organizations, the Board of Directors have Audit and Finance sub-committees in addition to organizational compliance and internal audit functions. On a regular basis, the Audit and Finance committees should review internal audit results and determine what should be raised for discussion with the entirety of the 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 all policies, reports, audit findings and any other issues with the Audit and Finance committees and with the entirety of the Board.

Physician groups that lack requisite governance skills 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 any compliance issues. These compliance functions, including hotline, can also be outsourced.

Economic Profiling – Narrow Networks

Of all of the issues arising from the downfall of this prominent medical group and its MSO, it is the policy concerns relating to “economic profiling” cited in the DMHC order that is causing “heart palpitations” in the California delegated model and resounding across other states utilizing 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 higher cost providers requires further stakeholder engagement and policy articulation by regulators.

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 per member per month basis. The health plan pays the IPA a capitation payment (generally a portion of the premium) on a similar per member per month basis. Under a capitated model, that represents all of the money available to take care of the patient.

For example, Covered California, the state’s health care 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, PPO products regulated by the DMHC offer tiered networks based on economic considerations. Therefore, the outstanding question is whether the DMHC will simply require a compliant filing or whether it will, “unmanage” managed care in California by forbidding provider pricing as a factor in narrowing network options? Stakeholder engagement, regulatory predictability and reasonable regulation are essential underpinnings to balance access to the best physicians and hospitals with the regrettable reality of cost.

Conclusion

While the need for higher scrutiny and stronger 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 delegated system in California for the "rules of the road" as they increasingly establish budget-driven, delegated and Medicaid responsibilities to managed health care 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 more safe and accountable care that shifts dollars from health plans to the front-line physicians.

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