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HEALTH PLAN DELEGATION MODEL IN THE ACA ERA

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A large physician management company with over 650,000 lives in California was shut down abruptly last year because of a whistleblower's report regarding poor delegation and delegation oversight.[1] The company had improperly denied care to thousands of patients, and even falsified documents to hide the misdeed. The shutdown forced health plans and providers to scramble to make transition plans and minimize impact to affected patients. This is a classic case of delegation gone awry, and everyone losing. In this instance, the company was fully delegated by health plans. But even for organizations not in or not contemplating full delegation, the organizations are most likely to operate in a manner that still requires regulatory compliance and oversight. The delegation model can be a critical avenue to decrease overall administrative expenses and improve efficiencies across the health ecosystem, but only when done correctly.

This paper examines the delegation partnership model between payers and providers, and includes details about the delegation process, benefits, and considerations.

The Health Plan Delegation Model

The health plan delegation model occurs when a payer holds the insurance license but delegates select insurance responsibilities to providers, such as utilization management and provider credentialing. This model has been around for decades, and is most prevalent in California where enrollment in health maintenance organizations with capitated payment arrangements is much higher than the rest of the country. However, delegation also works for preferred provider organization products, especially for risk-based contracts.

DELEGATION MODEL PROCESS

There are several strategic questions that both payers and providers need to consider as they go through the delegation model process:

1. Outline and align on shared vision with partner. → 2. Determine the best relationship structure to support the vision. → 3. Determine which insurance functions will be delegated. → 4. Determine the transition timeline for delegated functions.

1. Chad Terhune, "Whistleblower says Medicaid managed-care firm improperly denied care to thousands of Californians," Los Angeles Times, Nov. 30, 2017.

Step 1: Outline and Align On Shared Vision With Partner

The first step is to outline a shared vision with the partner. Key questions to consider include:

- What will the partnership look like?
- What is the overall philosophy for how the partnership will work?
- What are the shared values between the partners?
- How should responsibilities be assigned? What should be part of the decision criteria/framework to guide the selection of one party to be responsible for a role?
- What best-in-class benchmarks and measures should be used?
- How will changes be communicated downstream to providers?
- How will changes enhance patient care and/or administrative response?
- What are the short- and long-term goals for the partnership?

It is critical to engage key stakeholders and invest in what furthers a stronger partnership and a rewarding alliance. The goal is to have a defined and agreed-upon vision, and a detailed division of financial, administrative, and clinical responsibilities that will be the touchstone of the partnership, leading to product differentiation and venture parties in the market.

Step 2: Determine the Best Contractual Structure to Support the Vision

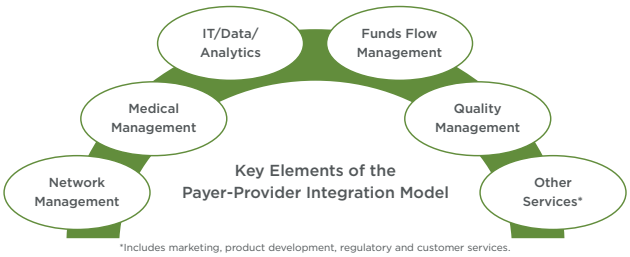
Determine the organizational structure that will most effectively support the outlined vision. The contractual structure of the partnership does not need to be limited to a specific arrangement. Rather, there are multiple ways to achieve the delegation model: (1) form an accountable care organization or clinically integrated network, (2) form a joint venture between payer and provider, or (3) form a new company entirely.

Additionally, consider what the contractual financial arrangement should look like. In general, the financial arrangement should reflect the delegated insurance function. Below is a broad guideline for what quality and medical management functions can be delegated based on the level of provider risk assumption.

For example, credentialing/re-credentialing can certainly be delegated delegated with little or no financial financial risk, while utilization management usually flows at the same time as downside risk. If utilization management is being delegated, the financial arrangement should feel, act, and function as high provider risk assumption.

Step 3: Determine Which Insurance Functions Will Be Delegated

After aligning on a shared vision and contractual structure, determine which functions should be delegated. Below are key elements of the payer-provider integration model:



Once payers and providers have thought through which key elements should be delegated, both parties need to further break down these elements to specific functions and determine which functions will be delegated to a provider as opposed to the health plan. For example, specific functions within medical management include:

- Utilization management including prospective, concurrent, and retrospective reviews, as well as out-of-network/out-of-service area care.
- Care/case management including inpatient/ambulatory, patient-centered medical home case management, palliative and end-of-life care, transplants, high-risk maternity, pediatric high risk and NICU, etc.

Depending on which functions are delegated, there are downstream implications to the staffing model and associated administrative fees. Even for functions that are retained, health plans should anticipate changes to how they would perform those functions, given that they are now being held accountable by the providers and the regulators (especially if providers are fully responsible for downside financial risk).

Delegated Functions Based on Provider Financial Risk Assumption

Delegated Function Areas	Low	Medium	High
Utilization Management	Retained	Retained	Delegated
Care/Case Management	Retained	Delegated	Delegated
Credentialing/ Recredentialing	Delegated	Delegated	Delegated
Member Complaints	Delegated	Delegated	Delegated

When deciding which functions should be delegated versus retained, payers and providers need to assess:

- Which functions make the most sense to delegate based on the agreed-upon financial arrangement?
- How ready are the providers to manage the delegated functions?
- How will the delegated and retained functions be performed differently to ensure no duplication of efforts/staffing?
- Which functions are regulated and, if assigned to the provider, how will they meet specific Centers for Medicare & Medicaid Services and State Department of Insurance process measurements?

The third and fourth points are related, in that certain functions, such as utilization management decisions and adverse determinations or denials, are highly regulated by state and federal entities, and therefore cannot be modified significantly. Other functions, such as care management, may not be specifically regulated by state or federal entities, and therefore allow providers significant flexibility to modify and adapt to fit the organization's needs.

Step 4: Determine the Timeline for Transitioning Delegated Functions

Finally, agree on a timeline to transition the delegated functions over to the provider. For this step, both payers and providers need to understand where they are today (current state) and outline where they want to be in the future (aspired future state). The readiness to move any and all delegated functions will depend in part on the provider's willingness and readiness to assume financial risk and delegated functions. Just as critical will be the other key enablers and dependencies, including but not limited to IT and data-sharing capabilities.

Payers and providers also have the option to transition the delegated functions over time, rather than all at once. The advantage of the staging approach is that it allows staff to focus on one area's change before another, as well as to address any barriers or unanticipated challenges before moving on to the next functions. When staging the transition, it is highly recommended that the delegated management is aligned with the timing of financial risk assumption.

BENEFITS AND CONSIDERATIONS

In deciding whether the delegation model makes sense, the organization should consider the benefits and considerations for both payers and providers.

Payers

The top three benefits for payers are (1) structured and sustainable relationship with a high-performing network, (2) potentially lower administrative expenses, and (3) more predictable medical expenses since the health plan is passing on some or all financial risks to the providers.

To achieve lower administrative expense, payers need to properly plan resource reductions and reassignments based on which functions are being delegated. Not doing this correctly could result in duplication of efforts/staff and therefore not achieve savings.

There are multiple risks from a payer's perspective to delegate select insurance functions to providers. First, payers need to approach data sharing strategically or they could risk being disintermediated. Second, payers need to maintain proper oversight over the delegated functions or risk losing star ratings, tarnishing their brand, or facing sanctions and penalties — potentially millions of dollars per year — imposed by state regulators. Even though payers are delegating select functions to providers, payers are ultimately legally liable since they hold the insurance license. As such, payers should develop reporting and evaluation requirements to ensure sufficient monitoring and accountability of delegated providers.

Payers should also lay out what remedial actions will be taken should providers neglect their duties and/or fail to pass an oversight audit. This could be a two-step process: (1) corrective action plan (with clear timeline, expectations, re-audit), and (2) de-delegation (bringing the functions back to the payers).

Providers

The top three benefits for providers are as follows. First, providers will have greater control and accountability over medical management decisions. How much say and control providers have depends on which functions are delegated. For example, if utilization management is delegated, providers would be able to decide if a patient needs specific services without going through a lengthy prior authorization with the health plan.

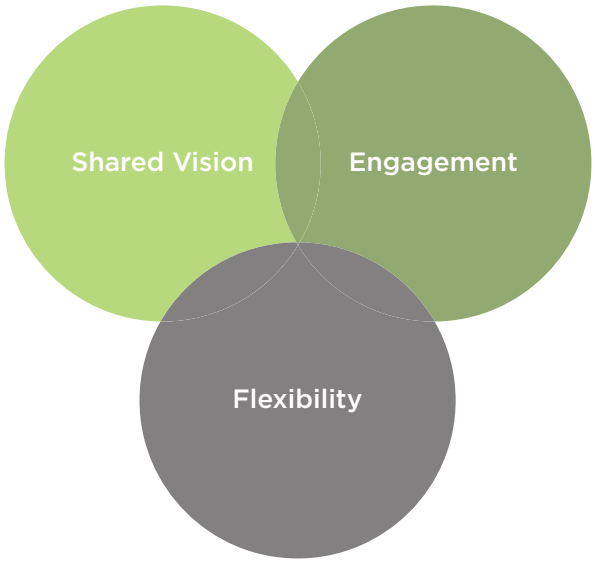
Second, providers would have greater access to real time data. There is tremendous value in getting greater access to data held by a health plan. Traditionally, health plans have been reluctant to share data, leading providers to rely on incomplete or delayed data to develop care plans for their patients. Having a rich set of data as close to real time as possible, will enable providers to do more sophisticated analytics, including identifying gaps in patient care, stratifying patients to different risk levels, and identifying low-performing providers and in- and out-of-network performance levels.

Third, providers could see financial gains. Successful provider groups have been able to achieve savings while also improving health status and experience of care under an upside/downside risk arrangement with appropriate infrastructure and process in place.

However, if providers cannot effectively perform the delegated functions and/or manage the financial risk, it could lead to poor patient care, poor provider ratings, and regulator intervention, as well as financial losses.

Implications

Payers and providers are increasingly thinking of innovative approaches to reducing overall healthcare costs, and right-sizing administrative expenses, as a means of creating competitive advantage in the market. They can and should explore whether the health plan delegation model can help them better achieve their goals. Those who determined this is the right approach should keep in mind these critical success factors:



- **Shared Vision.** Stay focused on what the goal is and don't be side-tracked by competing initiatives or uncertainty.
- **Engagement.** Beyond engaging with the leadership teams, remember to communicate with, and get buy-in from, the operational teams to foster true collaboration and partnership.
- **Flexibility.** Have a starting point for the specific arrangement, but be willing to adapt/modify as needed to meet the partner's goals/concerns. The proposed delegated functions and timeline can and should change if the provider is not ready to assume the responsibility.

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