Managed Models: FDR Delegation & Beyond

Service Delivery, Service Responsibility, and Service Ability

Richard Golfin III, JD, CHC, CHPC
Compliance Officer, CenCal Health
rgolfin@cencalhealth.org

Hello & Welcome: About Me
About CenCal Health

State and Federally Sponsored Healthcare

- Medicaid: Federal-State Partnership to provide healthcare to persons with low-to-no-income.

- Medicare: Federal health insurance program primarily for people age 65+ & persons with permanent disabilities.
  - 6MM Medicare recipients nationwide, 2.7MM in Medicare Advantage

Source: CMS.Gov/Medicare Enrollment Dashboard
Medicaid by the Numbers

- Approx. 73MM individuals enrolled in Medicaid & CHIP nationally.
- Approx. enrollment in CA: 13.3MM = 16%. (+4MM ACA)
- Largest Medicaid spend is also in CA, $85BB
- Elderly & Disabled = 60%, $51BB

As of November 2018 - KFF.org

California Medi-Cal Managed Care

- Medi-Cal Managed Care began in California during the 1970s.
- By the 1990s, almost all of the general Medi-Cal beneficiaries in the most populated counties were enrolled in managed care.
- In 2012, we saw a mandatory enrollment of Seniors and People with Disabilities into managed care.
- In 2013, expansion of Medi-Cal into rural counties.
- In 2014, expansion to Behavioral Health and launch of Cal MediConnect, Duals Demonstration
What About Oversight? Connect The Dots, Rich...

• Since 1965 Medicaid has evolved...

> Medicaid
- Children
- Low-income families
- Pregnant women
- Seniors and Persons with disabilities

> Medicare
- Part A: IP Hospital
- Part B: Outpatient
- Part C: Medicare Advantage/Managed Care
- Part D: Pharmaceuticals

> Marketplace
- Commercial
- Not Medicare or Medicaid
- Health Insurance Exchange (HIX)
- Obamacare
- Covered California

> Cal MediConnect (CMC)
- Both Medicare and Medicaid for Dually-eligible (MMP)
- Medicare and Medicaid Plan

• Our oversight methodologies have had to keep up with those changes

But why is this important? (Chapter 1)

> Them
- FDR

> Delegate
- Subcontractor
- Vendor

> His Company
- Over There
Vendor Management vs. Delegation Oversight

---

The Subcontractor Paradox

**Vendor**: An entity which performs functions, or provides services, to the Plan, on a cost basis.
- Typically structured in the form of an invoice.
  - i.e: Secure shredding, Nurse Advice Line, Call Center, Office Supplies, CVO

**Delegate**: An entity which bears risk on behalf of the Plan. Functions performed are leveraged on the basis of risk.
- Typically structured on a PMPM-basis and involve service-functions.
  - i.e: Physician Group, Management Services Organization, Behavioral Health Provider, Specialty Provider Group

What Defines a Delegate?

- A true delegate is based on an entity's ability to say “NO” on behalf of the Plan.
  - That “NO” is typically in the form of a denial
  - However, the NO is not required to be delivered to the member. We'll look into this more in a second.
Let’s Rehash…

**Vendor**: An entity which performs functions, or provides services, to the Plan, on a cost basis.
- Can any of these entities say "NO" to executing a function which is the plan’s responsibility?
  - Secure shredding & Recycling
  - Nurse Advice Line
  - Call Center
  - Office Supplies - STAPLES
  - Claims scanning and OCR
  - Clearinghouses
  - CVO
  - Privacy & Security Vendor

These are not delegates in this context, they are subcontractors/vendors.

---

Let’s Rehash…

**Delegate**: An entity which bears risk on behalf of the Plan. Functions performed are leveraged on the basis of risk.
- Focus on the ability to say "NO".
- I call this the "Decision Point"
  - Physician Group*
  - Management Services Organization*
  - Behavioral Health Provider*
  - Specialty Provider Group*
  - Scanning and Complex Imaging*

These are delegates AND subcontractors

*Can also be vendor relationship
Recap: Decision Point

The Subcontractor Paradox

- You Can Be A Subcontractor and A Delegate
- You Can Be A Subcontractor Alone
- You Cannot Be A Delegate Alone

\[
R_{\mu\nu} - \frac{1}{2} R g_{\mu\nu} + \Lambda g_{\mu\nu} = \frac{8 \pi G}{c^4} T_{\mu\nu}
\]
Quickly Recap

Subcontracted Relationships Defined

<table>
<thead>
<tr>
<th>Subcontractor</th>
<th>Administrative Vendor</th>
<th>Service Delegates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Downstream entity with or without decision points</td>
<td>Downstream entity with no decision points</td>
<td>Downstream entity with decision points</td>
</tr>
<tr>
<td>Can be a vendor or a delegate alone</td>
<td>Can be a vendor alone</td>
<td>Cannot be a delegate alone</td>
</tr>
<tr>
<td>Holds a contract with the Plan</td>
<td>Cost-basis contracting &amp; Payments</td>
<td>Risk-based contracting &amp; Payments</td>
</tr>
</tbody>
</table>

We’ll review this in a bit...

Service Delegates & Oversight

Mission
To coordinate and execute continuous oversight and monitoring of all delegated and downstream entities to ensure compliance with state, federal, accrediting agency, and Plan Policy requirements.

Vision
To position the Plan as a model sponsor of government programs that delivers quality care in the right place, at the right time, and to the right patient.

Utilization Management
Evaluates utilization program structure and design, to ensure utilization decisions affecting the health care of members occur in a fair, impartial and consistent manner

Claims
Evaluates financial solvency and monitors the timeliness of claims processing, timely payment & provider disputes

Credentialing
Evaluates the rigor of the process to select and evaluate practitioners to be included as part of the Plan network

Network Management
Management of a value-added network and strategic partner primarily focused on Network adequacy, Access and Availability
How We Audit

**Pre-Delegation Audit**
- Pre-delegation reviews are a part of the plans due diligence process
- Review policies & procedures
- Biographical information is collected and placed into databases

**Annual Audit**
- Onsite review is conducted and evidence collected is evaluated using standardized audit tools
- Interviews take place with focus on internal processes

**Post-Audit**
- Corrective Action Plans are issued for deficiencies identified during the Pre-Delegation or Annual Review
- Continuous oversight, monitoring and audit follow-up occurs through monthly and quarterly reports

**Regulatory Authority**
- Medicare Managed Care Manual: Chapter 11, 13, 110.2
- NCQA UM 15
- DMHC Knox-Keene, AB 1455
- DHCS/CCR, APLs and DPLs

A&M Cont’d.

**Corrective Action Plans**

- Non-compliance is identified based upon ongoing (monthly/quarterly/annual) monitoring
- Corrective Action Plan is requested when deficiencies have been identified or required elements not met.
- Deadlines set for response
- CAPs are reviewed & approved by D.O. staff

**CAP Issuance**
- Root Cause Analysis
- Systems Correction
- Re-Education (Onsite, Telephonic, Web)
- Implementation/Improvement of Delegates’ Internal Monitoring Process

**Remedial Actions**
The Hourglass

What’s next? Delegated Models
Medi-Cal Managed Care: Delegating Health Care Functions

But why is this important? (Chapter 2!)

Source: Mercatus.org and fticonsulting.com
Delegated Models and Integrated Delivery Systems

Delegation Breakdown: Structure
How It All Works

<table>
<thead>
<tr>
<th>Subcontractor</th>
<th>Administrative Vendor</th>
<th>Service Delegates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Downstream entity with or without decision points</td>
<td>Downstream entity with no decision points</td>
<td>Downstream entity with decision points</td>
</tr>
<tr>
<td>Can be a vendor or a delegate alone</td>
<td>Can be a vendor alone</td>
<td>Cannot be a delegate alone</td>
</tr>
<tr>
<td>Holds a contract with the Plan</td>
<td>Cost-basis contracting &amp; Payments</td>
<td>Risk-based contracting &amp; Payments</td>
</tr>
</tbody>
</table>

Delegation Breakdown: Risk-Based Contracting

Capitation → PMPM → Encounters
So Why CA?

Managed Care Models
(Cont’d.)
Recap: Basic Models w/ Direct Providers

Bringing It Back to Home Base

Two-Plan
- Members choose between commercial plan or local initiative
  - Local Initiative (LI)
  - Quasi-Government Agency
  - Commercial Plan (CP)
  - Molina Healthcare
  - Contracts awarded via RFP process

County Organized Health System (COHS)
- Locally develop and operated
- Governing Board approved by the County Board of Supervisors
- Health Plan created by County
- Mandatory Enrollment for MC population

Geographic Managed Care (GMC)
- Several commercial plans
- Noncompetitive application process
- No local/community or other government health plan
2-Plan & GMC Composition

So What’s Next…

Past
- FFS Fee for Service
- Health Care handled individually
- Poor Population Health Management

Present
- Unintended Consequences of Rate Setting & Waiver Programs
- Creative cost savings with less carve outs and more carve-ins

Future
- Whole Person Care & Whole Child Model
- Bio PSYCHO SOCIO
Thank You!

Richard Golfin III
Compliance Officer,
CenCal Health
rgolfin@cencalhealth.org