Delegation 101

Cal MediConnect Providers Summit
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DELEGATION 101
FOR CAL MEDICONNECT

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Today’s Webinar

- What is Delegation?
- Why Delegation?
  - Benefits & Pitfalls
- How Should Delegation Work?
  - MCP vs. Delegate vs. Provider Roles
- Delegation & Cal MediConnect
- Effective Delegation
  - Plan-Specific Delegation Oversight & Best Practices
- Improving Delegation
What is Delegation?
Defined

A formal process by which the organization gives another entity the authority to perform certain functions on its behalf. Although the organization may delegate the authority to perform a function, it may not delegate responsibility for ensuring that the function is performed appropriately.

NCQA Health Plan Standards, 2011
What is Delegation?
The MCP is still accountable.

The Managed Care Plan (MCP) is ultimately responsible for delivering needed care, no matter what services have been delegated by the MCP.
Why Delegation?

History of Delegation

- Delegation started as a way to share risk.
- Physician groups formed to allow providers to contract more efficiently with plans.
- We have seen some plans and many providers struggle from taking on too much risk.
- Important to balance the share of risk as well as care coordination and other patient care and management activities.
Why Delegation?

Benefits

- The MCP is able to share risk with a delegate, creating system stability.
- Delegation allows for a reasonable division of administrative and clinical management.
  - MCPs can focus on administrative and overview management.
  - Delegates can focus on clinical and patient management.
- Delegation allows providers to create strong networks among themselves.
Why Delegation?

Pitfalls

- Confusion among beneficiaries.
  - Where to go for services?

- Confusion among providers.
  - Who provides authorizations?
  - Where to file claims?

- Each delegation layer must communicate clearly and accurately with its adjacent layers—or it becomes a game of telephone.

- What happens if one layer could develop the competencies of another layer?
  - Concern that delegation leads to unnecessary overhead
How Does Delegation Work?
Four Steps in California Delegation

DHCS
- Sets Policy
- Manages MCPs and Payment

MCPs
- Capitation/Claims Payment
- Compliance
- Grievance and Appeals
- Responsible for Network Mgt.
- Monitoring Quality

Delegates
- Typically IPAs/Medical Groups
- Care Management and Care Delivery

Providers
- Specialized Care (SNFs, Hospital)
- Care Delivery
How Does Delegation Work?
MCP vs. Delegate Roles

- MCPs are responsible for:
  - Member services
  - Capitation and claims payment
  - Managing risk
  - Implementing state policy
  - Building networks
  - Promoting quality
  - Appeals and grievances

- Delegates are responsible for:
  - Managing their risk
  - Meeting their contract
  - Delivering quality care
  - Utilization management
  - Care coordination
How Does Delegation Work?
Delegate vs. Provider Roles

- A delegate is paid a capitated rate and takes on responsibility and risk for delivering all services in a contract.
- A provider is paid a set rate for delivering a certain service. The provider takes on limited risk.
Why has Cal MediConnect raised delegation concerns?

- From one payer to many
  - Providers now need to learn many more systems instead of just billing Medicare/Medi-Cal
- Providers feel a loss of control
  - Concern that even more change is coming
- Medicare raises the blood pressure
  - Medicare is less familiar with delegation
  - Medicare is a core business for many providers, so greater focus on ensuring patient access to care
Key Steps in Effective Delegation

Pre-Delegation:
- Constructing an Agreement
- Contracting
- Pre-Delegation Evaluation

Oversight:
- Performance Audit
- Performance Correction

Annual Evaluation

From NCQA
Pre-Delegation:
Contract Construction and Requirements

- Network development
- Write contract language based on master contract requirements
- Contract areas generally include:
  - Listing delegate activities
  - Reporting requirements
  - Evaluation requirements
  - Corrective action
  - Payment terms
Pre-Delegation: 
Pre-Delegation Evaluation

- Conduct extensive delegate evaluation
  - Site visit
  - Written review
  - Staffing capabilities
  - Performance records
  - Exchange of documents or through pre-meetings
- Credentialing evaluation
- NCQA calls for audit of 5% or 50 practitioner files
Oversight Stage: Performance Maintenance

- Review contractually established performance metrics monthly
- Use a range of data sources to evaluate coverage
- Immediately and clearly share new state guidance with delegates
- Set rules for sub-delegation
Oversight: Performance Correction

- Communicate overall needs to delegates—define big picture success for them
- Have a corrective action approach where an oversight steps for delegates who fail to meet expectations:
  - Calls
  - Letters
  - Corrective action plans
- Be prepared to terminate provider for failure to meet performance levels
Annual Evaluation

- Desk and onsite
- Evaluate adherence to plan and NCQA standards
  - Credentialing
  - Oversight requirements
Improving Delegation Systems

- Data reporting to DMHC/DHCS
  - Weekly reporting on claim timeliness – by delegate, CMC Medicare, CMC Medi-Cal, Medi-Cal
  - Percentage of claims rejected first time, second time
  - Total number of authorizations, to date, for a given period
  - Grievances and appeals
  - Length of time for approval of authorization
- Cal MediConnect federal evaluations
For More Information

- info@calduals.org
Delegation 101
Health Net of California

Health Net’s Delegation Oversight Process
Topics

① Definition for oversight by Health Net
② Definition of Health Net’s process
③ Scope of delegation activities
④ Pre-contractual process
⑤ Post contractual process
⑥ Appendix – definitions and reporting requirements
Health Net’s Delegation Oversight Process

• Health Net uses a delegated model to ensure our members receive the services necessary based on the assessed needs and benefit schedule.

• This delegated model brings the level of care to the member and their physician with minimal intervention needed by the health plan.

• Decisions therefore are made at the medical group/physician level.

• The health plan is involved for certain benefit issues and for those services for which the plan retains responsibility, such as transplants and experimental/investigational procedures.
Scope of Delegation Activities

• Health Net may delegate to certain contracted entities the responsibility for specific activities including but not limited to:
  – Utilization Management
  – Credentialing and Recredentialing
  – Special Needs Population Model of Care
  – Cal MediConnect Model of Care
  – Claims Processing and Payment

• The decision to delegate will be based on comprehensive on-site pre-contractual assessments/audits and at least annual assessments/audits thereafter.
  – Health Net can and does audit more frequently as directed by the Delegation Oversight Committee (DOC)

• Health Net retains accountability for all care and service delivered to members. The DOC is the accountable body that makes delegation decisions on behalf of HN.
Scope of De-delegation

• Health Net can revoke the delegation of any, or all, activities when it is determined by the DOC that a delegated entity is not complying with Health Net standards.
  – Any element that is less than threshold results in a Corrective Action Plan (CAP). (see thresholds in appendix)
  – CAPs are monitored until completion. If there are issue in completion of the CAP the DOC has an escalation action process including:
    ▪ Sanctions, freezing membership, delegation and or termination.
Pre-contractual Process for Participating Cal MediConnect Groups

• Our Cal MediConnect network is a tailored network and includes providers that generally meet our established criteria:
  - PPG ability to meet all requirements of Cal MediConnect Model of Care (MOC) and be fully delegated;
  - PPG with strong capabilities in RAF reporting, medical chart review accuracy;
  - PPG meeting quality requirements/STARS (minimum 4 Stars);
  - PPG and Hospital with aligned financial incentives, integrated delivery model - dual risk;
  - PPG has experience with dual eligible populations; and
  - PPG may meet special needs for certain service areas, special needs populations or service specific ethnic groups.

• PPG and/or Health Net contracting team approach each other regarding this new product.

• Internal discussions occur regarding capability of the PPG to accept this membership.
  – These discussions include whether to look at the PPG for possible delegation of the rigorous case management requirements.
Pre-contractual Process for Participating Cal MediConnect Groups (con’t)

• A Due Diligence (Pre-contractual) audit is scheduled for the PPG while the contracts are being negotiated.
  – This audit validates whether or not the PPG has the necessary policies and procedures, staffing and systems in place to meet the regulatory requirements.

• During this process, the Health Net team also meets with the PPG to share with them the requirements of the Cal MediConnect program (on boarding process).
  – This allows for questions and answers and clarification of the requirements.

• Due Diligence findings and contract negotiations are discussed at the next DOC (Delegation Oversight Committee) where the decision is made to proceed or not with finalizing the contract.
Delegation Oversight: Thresholds

Utilization Management including but not limited to:

- UM Policies and Procedures (P&P) must score 95% or better to meet full compliance for all delegated activities.
- UM File review must score 95% or better in both turnaround time (TAT) and notice content for all delegated activities.
- Model of Care case management requirements must also meet 90% compliance. (See appendix for reporting requirement and auditable items.)

In Addition for Claims Processing including but not limited to:

- Claims Check cashing TAT is 70% or better as an industry standard within 14 calendar days of issuing the check.
  - Commercial files include 45 day TAT, denials, denial accuracy, acknowledgements, contested claims, adjusted claims, provider disputes which includes 3 separate parameters.
  - Medicare files include 30 and 60 day timeliness, specific denial letter requirements.
  - Medi-Cal TAT’s also have requirements for 30 day and 45 day payment and levels of compliance.
  - Timeliness for nursing facility claims that compliance with the nursing facility DPL and the ability to accept claims electronically.

Health Net also continues monitoring for financial viability and reporting into the DMHC.

- If these thresholds are not met, a Corrective Action Plan (CAP) is required to be successfully completed. Failure to do so may result in withdrawal of contract negotiations or potential de-delegation of certain activities.
**Post contract “Go Live”**

- Delegation Oversight team and our Duals Program Office work directly with the PPGs to initiate and ensure timely and secure transmission of data to and from the PPGs.
  - This includes historical data given to the plans from the state and CMS.

- Delegation Oversight teams perform a post go live audit within 90 days of the contract effective date.
  - Ensures all processes have been adequately implemented and to assist the PPGs with any additional questions and guidance on the case management process.

- The Duals Program Office, in conjunction with other Health Net departments, sponsor what we call “PPG Huddles.”
  - These are educational seminars that are held every other month as a means to share new program-level information we have received from regulators as well as best practices with all our delegates.
Post contract “Go Live” (con’t)

• Delegation Oversight team and Program Office host monthly Case Management-focused huddles in addition to the Program Level PPG Huddles:
  - Focus exclusively on the case management and care coordination functions PPGs are managing.
  - The goals is to problem solve in real-time and make sure groups have easy access to answers and supports needed from Health Net in order to be successful.

• Our Provider Network (contracting) staff also continue to be involved in the roll out of this new product and work closely with both the Duals Program Office and Delegation Oversight team to ensure the success of this program for our PPGs and members.

• There are multiple data elements that are required for ongoing reporting on this population to the regulators as part of the delegation agreement. (See appendix for further detail.)
Thank You
Appendix
Definitions

• CAP – Corrective Action Plan. A written plan which specifies the actions to be taken, the responsible parties, and the timeframes within which said actions will occur in order to bring the delegated activities into compliance with Health Net and regulatory standards.

• Delegated Partner - Entity given authority to perform certain functions on behalf of Health Net. Those functions include but are not limited to claims, customer service, utilization management, complex case management and disease management, SNP Model of Care, Cal MediConnect Model of Care, long term care management.

• Delegation - The formal process by which Health Net determines whether or not a partner is delegated the responsibility for performing specified activities in any of the following programs including but not limited to: Utilization Management, Claims Processing, Customer Service and Member Connections, Disease Management, Complex Case Management, Pharmacy management, Behavioral Health management, credentialing and recredentialing, long term care management, Appeals and Grievances.

• Delegation Agreements - Delineate the specific responsibilities, functions and activities of the delegate and Health Net, including the remedies available to Health Net if the delegated partner does not fulfill its obligations. Delegation agreements must be signed by both Health Net and the delegated partner.

• Delegation Threshold Elements — Elements identified by Health Net’s DOC as basic essential structures or processes, which, if not adequately and appropriately implemented by the delegated partner, may prevent the approval of delegation.

• DOC – Delegation Oversight Committee is a multi-disciplinary committee responsible for making delegation decisions and overseeing the ongoing compliance of delegated partners.

• DOW – Delegation Oversight Workgroup reports to the DOC the results of all ongoing assessment/audit findings and progress of Corrective Action Plan activities for delegated partners. The DOW includes the recommendation concerning granting of delegation in their report.
• PPG – Participating Physician Groups are the contracting medical groups or independent practice associations to whom Health Net may delegate specific functions

• Provider – An institution or organization contracted to provide services for Health Net members including but not limited to Participating Physician Groups, ancillary providers and hospitals.
Cal MediConnect Reporting Requirements

• These are existing elements and subject to change:

• Case Management reports due monthly to HN
  – There are multiple line items in this report that are fields HN has to report to the regulators including but not limited to:
    ▪ Care plan established within regulatory time frame
    ▪ Member centric goals with member input into establishing those goals
    ▪ Must include documentation that the goals were discussed with the member
    ▪ Documentation of at least one care team contact annually.
    ▪ Development of an Interdisciplinary Care Team (ICT) to include the member. Member must have a say in who can be on the team.
    ▪ New requirement for ICT – must involve the member’s IHSS Social Worker
    ▪ Care plan must be updated at a minimum of annually or as the member’s condition changes.
    ▪ Coordination with behavioral health providers
    ▪ Documentation of unmet needs for IHSS
    ▪ Documentation of members with a follow up visit within 30 days after a hospital discharge
• Inpatient admission/transition logs due monthly to HN
  – Again, multiple line items that are reportable to regulators combined into this one template including but not limited to:
  – Admission and discharge dates from both acute care facilities and skilled nursing facilities
  – Estimated lengths of stay
  – Documentation of any complications
  – Discharge diagnosis and disposition – where did the member go
  – The most important is if a transition record was sent to the receiving facility/PCP/responsible party within 24 hours of the discharge and documentation that this process was completed.

• Part C reporting quarterly separate from other MA line of business for both UM and claims
Definitions of Delegation Oversight for Health Net

- **Delegation** – The formal process by which Health Net determines whether or not a PPG (Participating Provider Groups)/vendors is delegated the responsibility for performing specified activities in any of the following programs: Utilization Management (UM), Claims Processing, Credentialing and Recredentialing processes, Complex Case Management, Special Needs Population Model of Care, Disease Management, Member Connections, and/or Customer Service. Health Net can revoke the delegation of any, or all, activities when it is determined by the DOC (Health Net’s internal Delegation Oversight Committee) that a delegated partner is not complying with Health Net standards. Health Net standards are in agreement with the standards of the Center for Medicare and Medicaid Services (CMS), the California Department of Health Care Services (DHCS), the California Department of Managed Healthcare (DMHC) the National Committee for Quality Assurance (NCQA), the Arizona Department of Insurance (DOI), Arizona Health Care Cost Containment System (AHCCCS), Washington Department of Insurance (DOI) and the Oregon Insurance Division (OID)

- **Delegation Threshold Elements** – Identified by Health Net’s Delegation Oversight Committee as basic essential structures or processes, which, if not adequately and appropriately implemented by the PPG/Provider, may prevent the approval of delegation

- **HNCA Demographics**
  - Oversight all three lines of capitated business – Commercial, Medicare Advantage, which includes Special Needs Population (SNP), Medicaid and Cal MediConnect

  - Current oversight for Cal MediConnect of:
    - 19 Participating Physician Groups (PPGs)
    - 30 Capitated facilities
    - 1 Non-Capitated entity (credentialing only)
    - 4 Health Net Capitated vendors
Examples of PPG Huddle Topics

- 6/16/14 - Data Exchange and Portal Walk-through – accessing Care Documents on the portal. This is one of the means for data transmission to the PPGs

- 7/15/14 - Physician Summary - summary of the historical data from the regulators in a format for PCPs and PPGs put into a member profile to assist in getting their members needs identified and met. Includes information obtained from the HRA (Health Risk Assessment)

- 7/29/14 - EFT (Electronic File Transfer process) Data Schedule – how soon each PPG can get this process going for ease of data transmission to and from the PPG to HN.

- 8/12/14 - IHSS (In Home Support Services) Program Overview & Referral Process / HEDIS (Healthcare Effectiveness and Data Information Set) Quality measures and why they are important

- 8/29/14 - Nursing Facility Authorizations and Claims payment processes.

- 11/17/14 - Operational Updates (download tool, new case coordination documents, new member data extracts, new reports available), January Enrollment & DSNP Transition, and LTSS Performance Program.
CCI and Delegation 101

How Plans and Providers Work Together to Make CalMediConnect
Kathy Hegstrom, President, AMM
Seoul Medical Group MSO
How AMM Works with Plans, Providers & Patients

AMM Departments and Teams

◦ Provider Office Support Team
◦ Patient Centered Data Warehouse
◦ Patient Assessment Team (Case Managers)
◦ IDCT – Individual Care Plan (HRA)
◦ Contracting Team – COC/LOAs
Working with Plans

- AMM works with 3 CMC plans in LA County
  - HealthNet CMC is the only Dual-Risk plan
  - LA Care and Care1st are Shared Risk, and delegation is reduced

- One Capitated Financial Alignment Demonstration Plan (C-FAD) in Imperial County
  - Looks like a CMC in many respects, but without some of the specifics
Working with Providers

Provider Office Support Team

- The Provider Office Support Team assists providers and their staff with training and support
  - Contacting members to schedule Initial Assessment Visit
  - Assisting offices with training on requirements of CMC
  - How to coordinate benefits (Medicare vs. Medi-Cal)
Patient Data Warehouse

Software created in-house to assist Case Management Team with all of the data and forms required. Brings in data from internal (EZ-CAP, Cerecons, other) and external (lab results from K-LINKS files, pharma data from plan) sources into one user-friendly program. Assessment forms and care plans are imbedded into the program so each member’s care can be tracked and reported. Available to all AMM staff authorized to view patient information.

Patient Assessment Forms

Customer Service Representatives and Case Management Coordinators make outbound calls to new and other identified members to start the Assessment Form process.
Issues to Deal With

- Continuity of Care: one of the biggest and most-pressing issues. Contracting staff set up to get information directly from a queue in Cerecons containing information for LOA.

- Complex Case Management: Delegated for Dual-Risk contract, retained by plan in shared-risk contracts.
Issues, cont.

- Eligibility: shared between POS, UM and Elig. Departments. POS Team trains offices in how to identify CMC members. UM system routes referral requests to Unknown Member Queue so Eligibility staff can research. Usually completed within 4 hours of initial request.
Health Net: Provider Hand Off Training
- Teams from Plan and MSO meet to discuss all aspects of CMC. Sharing of forms, FAQ, Portal access, reporting timelines and contact information for both teams.
- Meetings to be held at regular intervals to update teams and assure all requirements are met.
- LA Care and Care1st: Kick-off meetings held in Q3/Q4 to help groups prepare.
Thank You

- Let’s hear about “Best Practices” from PPGs.
Questions and Discussion