# SynerMed Fallout: The California Delegated Model Is at Risk

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For more than 40 years, the state of California has embraced the policy of moving healthcare dollars closer to the actual providers of care through capitation (per-member, per-month payments). Although there is a risk that these prepaid payments may not be adequate for all necessary services, a system of laws and regulations has developed over time[1] to ensure that patient care in a capitated, delegated[2] delivery model meets quality standards, and that the provider groups' finances are stable.

Despite the large-scale success of this model over the past 17 years[3]—with most risk-bearing organizations largely financially compliant[4]—recent state regulatory decisions have engendered great uncertainty and instability in California's capitated, delegated model.

This case of regulatory overreaction comes at the very time when credible evidence supports the superiority of this model over fee-for-service payments in cost, coordination of services, and quality. For example, the Integrated Healthcare Association has conclusively demonstrated that HMOs in California using delegated providers are delivering higher quality at lower cost than PPOs.[5]

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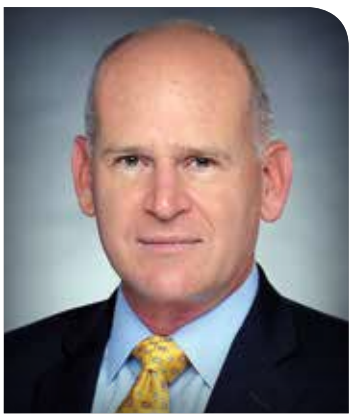

*Allen Miller*

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## WHAT HAPPENED TO SYNERMED?

The failure in early 2018 of Southern California-based SynerMed—one of the state's largest management services organizations (MSOs)—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.[6] The strong appearance was that EHS—the largest medical group that contracted SynerMed—had failed to exercise any meaningful oversight of its wayward MSO.

The California Department of Health Care Services (DHCS) stepped in in late 2017 and imposed a corrective action plan, whose terms SynerMed arguably met. Nevertheless, in response to a second whistleblower complaint, the California Department of Managed Health Care (DMHC) stepped in in early 2018, despite its tangential oversight role over medical groups and MSOs.

Rather than requiring its own customary corrective action plan,[7] the DMHC ordered all plans to terminate their contracts with EHS and expeditiously transfer 600,000 patients—90 percent of whom were Medicaid (Medi-Cal) patients. This action effectively shut down both SynerMed and EHS—despite a lack of documented systemic or egregious patient harm that typically undergirds precipitous regulatory action that bypasses administrative and due process norms.[8]

## FUNDAMENTAL GAPS

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—especially for small providers—but potentially may lack accountability and proper oversight
- Questions as to whether capitated providers are improving their increasingly important quality scores, particularly in Medi-Cal, and providing value for their share of the premium dollar
- Issues as to how much of the state's skinny Medi-Cal premium dollar is getting into the hands of the actual providers of care

High-quality healthcare is getting more complex. Health plans' expectations are redefining efficient and effective care to embrace "whole-person care"—addressing social determinants of health and higher quality of care.[9] This requires coordination of care and contracting with community-based providers. These essential relationships are best coordinated with treating and risk-bearing providers who manage cost and are accountable for quality, rather than with a distant health plan.

Because medical groups and health systems taking capitation (particularly in Medi-Cal) now face greater complexity, they increasingly may rely on contracted third-party MSOs for managing risk-contracting, coordinating care, and handling other administrative services. These third-party entities by contract must adhere to the same 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 approached these issues in a way that created uneven enforcement, uncertainty, and unnecessary administrative costs for providers.

Their approach risks undermining confidence and placing increasing financial and administrative strain on the largest delegated system in the country. This could have unintended consequences for Medi-Cal—where contracted managed care organizations are deeply dependent on capitated, delegated payment models to provide healthcare for 10.5 million members.[10]

## HOW SHOULD REGULATORS RESPOND?

An appropriate regulatory response to these legitimate concerns should bear the imprint of seven characteristics:

1. **Necessity**: It should respond to a clear issue or market failure and address bad behavior.
2. **Transparency**: Regulators should not hide behind opaque bureaucratic walls.
3. **Due process**: Broad stakeholder inclusion and process are essential to credible regulation.
4. **Predictability**: The regulation should create more certainty in the relevant market.
5. **Proportionality**: Regulation should be measured and should strive to impose the least burden possible to solve a problem.
6. **Level playing field**: Rules must apply equivalently to all relevant stakeholders.
7. **Measurable and measured effectiveness**: Regulations without meaningful and measurable enforceability undermine their legitimacy.

### 1. Necessity

As accountability moves from a directly regulated health plan to delegated providers to MSOs, the DMHC is right to refine regulatory oversight. Further, while profiling contracted primary and specialty providers is integral to narrow networks and increasingly associated with highest-value care, it must ensure access to high-quality providers, not merely the cheapest. Ensuring this patient access to medically necessary services requires refined, legally discriminatory referral processes based on transparent criteria.

The complexity of multiple relationships can make it difficult to know which party is doing what and with what degree of compliance. On the other hand, there is relatively scant evidence of actual consumer impact that will offset the costs and burdens of mushrooming standards and scrutiny.

### 2. Transparency

Agencies that address broad industry issues should be equally accessible to all affected parties, transparent in their process, and forthcoming with performance measurement information. Unfortunately, with SynerMed, the DMHC—working closely with DHCS—launched an investigation that is still ongoing after 18 months. Moreover, it did this without publicly revealing the findings to justify its termination order, and without providing guidance on what policies and procedures must be followed to engage in "economic profiling"[11] of providers.

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No health plan has been sanctioned for its provider selection policies. The DMHC met with health plans regularly and exclusively over many months—without scheduling similar communication opportunities with contracted providers. As the DMHC expands its direct oversight of these providers and MSOs, transparency is needed. That must include open communication and the sharing of substantiated findings and desired remedies.

The department should release its investigative findings. This would counter the perception that its waiving of traditional requirements for transferring patients to a new network of providers was unwarranted by actual or imminent patient harm.

### 3. Due Process

Historically, DMHC staff communicated in a two-way fashion with members of the public and industry and consumer stakeholders—answering questions informally about the intent and meaning of proposed regulation.

Such communications did not make commitments to a particular course, but they 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—lack credibility. Regulators must adhere to the tradition of open access to the regulation development process.

### 4. Predictability

California health plans are under intense pressure from regulators to strengthen oversight and audits of delegated providers and MSOs. The California Legislature is also seeking more frequent and "surprise" Medi-Cal audits.[12] Regulation carries serious costs in time and money. The state and plans are not adding dollars to cover providers' increased administrative costs, so these actions risk depleting dollars needed for medical care.

Targeted surprise enforcement actions that respond to a clearly identified concern can be an appropriate tool. However, this "gotcha this time!" approach—used on a broad, vague basis—creates an unpredictability in scheduling, scope, and sampling that significantly increases administrative burden and costs. Further, it risks creating "one-off" audit results that reduce the ability to compare industry conduct and bring defensible enforcement actions.

Importantly, MSOs' actual day-to-day work is being adversely affected by the many audits resulting from the SynerMed problem. Over the last year, some MSOs, medical groups, and IPAs appear to be facing multiple audits each week—many on a surprise basis. At the same time, while one MSO is reporting 2,000 audits, others are seeing no change in oversight.

Most MSOs lack the staff to comply with multiple unannounced simultaneous audits—which have different and conflicting information demands. This can severely delay audit processes. In addition, a lack of agreed upon compliance standards creates disagreement among auditors at the same plan. This results in internal arguments while at an MSO for an audit.

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." An industry guidance—promised more than a year ago—needs to articulate the lawful boundaries of this practice, which is used by every health plan and insurance carrier to narrow networks and manage the high costs of healthcare.

Another appropriate area for guidance is the utilization management process. Currently, there are no standards for how many physician medical directors must be available for a certain volume of claims. This results in a wide variance of staffing ratios. Regulators need to structure clear guidelines for accepted staffing and approach. This would prevent "after the fact" second-guessing and provide both a "safe harbor" and a baseline best practice to ensure the quality of the utilization management process.

### 5. Proportionality

Regulation should strive to impose the least burden possible to solve a problem. This requires a deep understanding of the issues. Gathering information and convening stakeholders are paramount in an area where the industry has appeared to fail to understand the intricacies of delegated providers' downstream partners. These concerns go beyond a few "bad apples" and include the complex contractual and variable financial obligations undertaken by capitated providers.

Despite complexity, burdening all capitated/delegated providers (particularly smaller entities) and their MSOs with massive licensing filings and uncoordinated, expensive audits seems out of proportion to the actual problem. Again, the department would gain credibility from a stronger showing of actual misdeeds resulting in patient harm.

### 6. Level Playing Field

Rules must apply equivalently to all relevant stakeholders. Regulation should strive to preserve a level playing field among different-sized provider organizations actively engaged in cost, quality, and access objectives. DMHC regulatory tweaks could inadvertently favor or disfavor certain kinds of providers or payers.

Ironically, the approach taken by DMHC and DHCS will impact ethnic providers more than others because ethnic providers generally are more dedicated to serving Medi-Cal patients. Such inadvertent favoritism could drive smaller and cultural provider organizations from the market—reducing competition, increasing costs, or lowering quality and access to culturally competent care.

Smaller medical groups and MSOs also are adversely affected. This likely will result in a further wave of consolidation in California, rather than improvement and support for these providers.

**7. Measurable and Measured Effectiveness**

A lack of meaningful and measurable enforcement undermines regulations' legitimacy. This is a very serious risk with both current compliance enforcement and the financial risk licensing regulation.

Compliance audits of delegated providers lack uniformity. Using common standards will allow credible measurability of care and compliance. (Worthy of note is APG's newly released "Code of Conduct and Audit: Compliance Capabilities for APG Members," which provides a suggested framework for developing internal organizational capabilities to meet regulatory administrative compliance standards.)

Joint audits may not be appropriate. However, common audit standards for utilization management and a clear definition of impermissible "economic profiling" in Technical Assistance Guides (TAGs) would allow delegated providers to conduct internal pre-audits—and contracted health plans to conduct external audits. The DMHC should consider creating a deemed status for a certified delegation oversight audit organization that health plans could use to meet their oversight obligations. This would increase the level of intense audit scrutiny but reduce the administrative burden by having fewer audits.

The department should also establish a protocol for a "lead plan" to conduct the audit, to obtain input and coordinate questions from the other contracted plans, and to share its findings with those plans. This would result in faster and more efficient audits, and would not impede daily MSO operations for patients and providers.

Finally, date changes and other data adjustments have been an issue in many recent MSO investigations. In the era of sophisticated information technology, regulators should establish a minimum technology requirement (such as systems that irrevocably capture the initial claim or encounter submission and that have strong protected audit trail functions), as well as internal and external audit requirements. This will reduce the opportunity for fraud and improve the integrity of the system.

## CURE, DON'T KILL

As the saying goes: "Bad cases make bad law." SynerMed has literally changed the California health industry and raised the question of 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 IPAs and medical groups, we need measured action with mutual accountability for solving industry issues. Because when delegation works, it is superior 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 Knox Keene Health Care Service Plan Act of 1975, H&SC Sec. 1340, et seq.*

*[2] In California, 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] Regulatory reforms enacted in 2000 led to greater financial and operational stability of medical groups and IPAs bearing delegated risk and healthcare services obligations.*

*[4] https://www.dmhc.ca.gov/Portals/0/Docs/DO/FSSB%20October%202018/meetingMinutes_10_17_18.pdf*

*[5] https://atlas.iha.org*

*[6] California Department of Managed Health Care, Order to Cease and Desist, December 26, 2017. The original SynerMed press report alleged that "thousands of patients" were denied care. That provided the rationale for a regulatory response that skipped due process for the affected companies—and skipped protections for consumers against abrupt termination of provider relationships. However, almost two years later, consumer advocacy groups only point to one or two denial-of-care complaints received from patients. Health plans also report that no denials of care were detected after the whistleblower complaints were filed, despite the fact that they were ordered by regulators to contact every patient who had received an authorization, modification, or denial by SynerMed.*

*[7] See the department's recent approval of CVS' acquisition of Aetna Health Plan, which Order noted low OPA report card scores on "Getting Care Easily" reflecting barriers to timely access to care and outstanding persistent issues related to grievance handling. This resulted in a mere requirement to improve those scores within 12 months. California Department of Managed Health Care, Order, November 15, 2018. DMHC Approves CVS's Acquisition of Aetna*

*[8] CA Legislature, SB503 Medi-Cal: managed care plan: subcontracts (2019-2020)*

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

*[10] https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report/resource/95358a7a-2c9d-41c6-a0e0-405a7e5c5f18*

*[11] California Health & Safety Code 1367.02 requires, for purposes of public disclosure, that every healthcare service plan 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.*

*[12] Licensing Reg: Title 28, California Code of Regulations Division 1. The Department of Managed Health Care Chapter 2. Health Care Service Plans Article 2. Administration Section 1300.49 General Licensure Requirements*