The Important Role of Management Services Organizations

In California Managed Care

Introduction & Purpose

Management Services Organizations (MSO) are business organizations that provide the necessary administrative infrastructure, scale and technology for risk bearing organizations to function successfully in their relationships with contracted payers and regulators. In California, over 205 MSOs operate to provide services to 300 or so risk bearing physician groups and other entities, such as FQHC clinics, hospitals, and even health plans. Some MSOs may serve only one client physician group or other MCO ("captive model"), and others may provide their services to several groups and vary their client list over time ("contracted-independent model"). This whitepaper will focus on the role of independent MSOs that contract with various risk-bearing physician groups.

There are approximately two-dozen independent MSOs that provide services to independent contracted provider organizations out of over 200 operating in the California healthcare system. Table 1 provides a summary of these organizations. They vary in size from as little as 10,000 lives to over 1 million.

MSOs provide value in the California healthcare system when they enable physician organizations to succeed in the assumption of financial and population risk, to improve the organization's performance in care delivery, and provide the data analytics necessary to meet the goals of the Triple Aim – better care, lower cost, and improved patient experience. The high-performing MSO will provide a variety of services and capabilities to a contracted physician organization that it could not otherwise afford to operate in-house. This is particularly true in Medi-Cal, where capitated payment rates fluctuate and are generally lower than in other payer streams.

Recently MSOs have faced criticism in the Medi-Cal Managed Care market. The chief allegations have been that MSOs have failed to provide the necessary level of compliance and accountability in claims and utilization management on behalf of their client organizations. Some have speculated that MSOs only add more layers to the managed care process without delivering value. In fact, MSOs have provided the needed infrastructure and administrative management to physician practices that cannot cope on their own with the rapidly increasing administrative requirements in Medi-Cal managed care. Without competent MSO management, there would be fewer physicians participating in the Medi-Cal system and beneficiaries would receive lower quality care.

Why is it important to the healthcare system that providers accept financial risk and develop integrated, coordinated patient care models? Recent data developed under a grant from the California Healthcare Foundation and presented by the Integrated Healthcare Association shows that on a regional basis, such provider delivery models out-perform more traditional networks of "fragmented" providers paid on a purely fee-for-service basis. The data, available at www.iha.org. indicates that these risk-bearing providers operating in an HMO coverage model provide better quality care at a lower per-capita cost,

saving the California healthcare system $3 billion annually.[1] There has been significant study and comment concerning provider consolidation over the past decade. Since independent MSOs enable a greater number of RBOs to operate in the marketplace, competition is also increased.

California MSOs have provided actionable data analytics to enable physicians to identify at-risk patients so that they can engage and intervene to improve a patient's health status. They have developed support services that include additional care coordination staff, patient scheduling and outreach, provider education, compliance expertise and staffing to handle audits and reporting requirements, and adequate legal and contracting support. We will explore these functions further in this whitepaper. An important point to remember is that MSOs provide localized capabilities and service – because effective health care is local in nature.
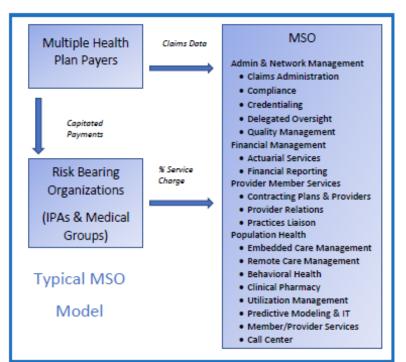
Smaller, predominantly Medi-Cal-oriented physician organizations would not be able to sustain their practices. These physician practices were not provided funding to improve their care delivery infrastructure under the Hitech Act, the ACA, or in any California innovation waiver. They cannot afford to purchase electronic infrastructure, let alone have the time to properly use it for actionable data analytics that can help to improve their care delivery. They cannot cope with the administrative burdens that arise from contracting with several health plans. There would be further consolidation across the market of physicians, less organizations for health plans to contract with to form their networks, and there would be less physicians interested in seeing Medi-Cal patients.

Contracting with an MSO.

What type of provider groups seek management services from MSOs? Small and medium-sized capitated-delegated physician groups seek management services from MSOs for their Medi-Cal business, as well as other payer lines, like Medicare and commercial health plan HMO or PPO. Federally Qualified Health Centers also contract with MSOS.

The typical MSO arrangement is structured such that a health plan payer contracts with the IPA or Medical Group to pay capitation based on the number of lives cared for by the group or clinic. The IPA or Medical Group contracts separately with the MSO for a small percentage fee, based on the number of lives in the group, or a flat service fee.

Typical MSO Model

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[1] Milliman, Chris Girod, July 16, 2018, Healthcare Under the Delegated Risk Model in California: Lower Cost, Higher Quality. Accessed at https://www.healthcaretownhall.com/?p=9535#sthash.qlBOGSPx.dpbs.

The MSO coordinates data exchange with the client-contracted health plans, including claims & encounter data reporting, and performance reporting.

Common Services & Functions

There are six critical dimensions to the services provided by contracting MSOs to their client physician organizations:

Consumer Experience: MSOs can provide local assistance to physician practices in coordinating the scheduling of patients. This accelerates the patient's access to care and focuses on warm handoffs between providers that improves the patient experience. They aid with patient outreach that is focused on cultural & linguistic needs, and that is also targeted to improve patient understanding, engagement & adherence. MSOs can provide care coordination staff that monitor admissions and discharges, following up directly with patients, explaining medications, setting follow-up appointments and checking in on patient progress. These services deliver the high-touch that is necessary to achieve superior outcomes for patients that are chronically ill, elderly, or have difficulty navigating the system on their own.

Utilization Management: MSOs can manage the job of determining patient eligibility and enrollment, a frequent task that involves data exchange between the payer plan and provider organization in a managed care system. When a physician organization contracts with several health plans, there is a constant exchange of eligibility files between the plan and group that requires experienced administrative staff and IT support. Denials are sometimes necessary, and usually run at a rate of no more than 4 percent of all authorizations that are handled on a monthly basis. Denials of services require prompt attention that necessitates adequate staffing. MSOs also maintain a staff of their own medical officers and nurses to provide the necessary clinical oversight during this process. Accurate, auditable records of these activities must be maintained and frequently provided to plan and regulatory reviewers. The scale of the MSO provides that level of competent service to smaller physician organizations.

Clinical Information: Capitated-delegated physician organizations must report encounter and claims data to each of their contracted health plans. This is usually facilitated through data exchange with an intermediary like Transunion. MSOs maintain experienced staff and up-to-date claims processing infrastructure that smaller physician organizations cannot afford to maintain. MSOs also provide services to help provider organizations

educate their physicians and staff on proper reporting and assist with data error correction to achieve higher accuracy. Most physicians in managed care systems must also report on over 230 separate quality measures to various payers like CMS, health plans, Medi-Cal and Covered California. This is a daunting task to capture and translate clinical data obtained at the provider level and transmit it in the appropriate form and timetables required. Moreover, the real value of a good MSO is its ability to make clinical data actionable for its clients, for use in population health management, network management, and risk-assessment.

Administrative & Risk Management: Provider organizations are formed under California law to require only licensed clinical professionals within the group. Lay people are not permitted to own medical groups or IPAs. Many smaller physician organizations are organized as shareholder medical groups made up of practicing physicians. MSOs have the scale to hire competent, experienced management and staff with financial, actuarial and IT skills. The MSO provides the right capability to assess risk-based, capitated contracts with payers. Risk-bearing organizations (RBOs) must also provide financial solvency reporting to the DMHC on a quarterly basis and are sometimes subject to corrective-action plan compliance for both financial and clinical processes. MSOs provide the help necessary for sustainable compliance. They also provide legal and operational support to keep the practice running.

Population Health Management: The successful management of large patient populations requires the collection of accurate patient data and its comparison to clinical data, social determinants factors, and physician performance data. There are many sources of information available to physicians but there is little time and capability to integrate and analyze that information to achieve better patient care and outcomes. MSOs can provide the IT systems to identify sub-groups of patients within an overall population, like obese diabetics, or seniors with three-or-more co-morbid conditions. They can analyze access, outcomes, and determine best practices that can be communicated to the treating physician, resulting in improved care and patient experience. Many MSOs now use predictive analytics to determine at-risk patient sub-populations, so that clinicians and care coordinators may intervene to avoid a patient becoming chronic, or to improve their medication adherence, and better coordinate their care. This kind of information empowers physician organizations to develop patient outreach strategies and to better manage the daily workflow of seeing patients and ensuring that they receive the preventive care needed. MSOs can now help physician practices leverage their own data to enable real-time information dashboards. These systems allow physicians to see their patient population at a glance and determine which preventive measures are needed based on the individual patient's risk scoring and medical history.

Clinical Integration & Physician Alignment: MSOs help physician groups acquire and maintain the various doctors necessary to provide a complete spectrum of care. There is a constant changing of clinicians and staff, necessitating recruitment, training and development of various professionals. There must be administrative organization to keep clinicians updated on best practices, legal requirements, new standards and techniques. MSOs can provide the staffing needed for a group to meet the network size and capacity requirements to maintain health plan network contracts, meet quality standards, and expand their operational area. MSOs can also provide the management expertise to develop a successful physician culture within the organization, which promotes tighter alignment of purpose and goals within the organization.

Developing a Provider Office Support Team: The MSO formed a team of administrative and clinical professional to assist the client physician organization in meeting requirements such as HEDIS quality reporting and other Quality measurement programs. The team identified a better workflow process for the client organization, so they did not feel overwhelmed by all the requirements in a managed care system. The POS Team even assists offices with understanding how to better use EMR systems to help with their workflow. A team schedules provider education meetings and one-on-one's so providers can better understand guidelines and criteria such as those from health plans, Milliman and others. As the California Medi-Cal system moves toward the implementation of risk adjustment factors, the Provider Office Support Team model will help client organizations understand how to meet the new requirements.

A Dedicated Customer Service Team: The MSO forms a team that is assigned to the specific client organization. Many times, it is cultural/linguistic specific to enable better patient experience and outcomes. The team and client bond over time and develop a working relationship that tackles a variety of performance improvement and compliance issues as they arise.

Case Manager Support: Where smaller physician groups cannot afford to hire care coordinators for the Medi-Cal population, the MSO has the right scale to do so and provide that service to its client groups. Care coordinators are frequently cultural/linguistic based. Some are based in the area of transitions of care from acute facility to a lower level of care, making sure any needed supplies and equipment are available. They are also very effective to deliver medication reconciliation with a recently discharged hospital patient in order to avoid readmissions. Other case managers are assigned to follow any identified members at high risk for being admitted to hospital or with deterioration of health status without this service. This includes the subpopulation of patients with multiple, chronic co-morbidities. Members are identified through many different methods, including contact from physicians, care givers and family, claims data, lab data, UM data and predictive analytics.

Hot-Spotter Clinic Models: MSOs can and have developed special clinics for their client physician organizations that enable them to aggregate resources in order to deliver highly integrated social determinant-related services along with medical care. A single medical group may not have enough high-risk patients to support such a high-touch clinic model. These clinics have been highly successful and have saved millions of dollars in health care costs and vastly improved the lives of patients who would have otherwise slipped through the cracks of our healthcare system.

Problems in the MSO Sector

Not all organizations are equivalent in their performance, competency, and value. There have been unfortunate, somewhat appalling instances of non-compliance in the past two years that prompted a serious examination of managed care structures in California Medi-Cal. Because the California delegated model is not directly regulated, the increasing need for delegation oversight is straining the system. When a single organization contracts with multiple payers, often as many as 10 health plans, each IPA or medical group is subjected to at least 10 annual audits by their contracted plans. If the group participates in Medi-Cal and Medicare Advantage, the number of audits increases due to the specific

requirements of those programs. In addition, regulators schedule routine periodic audits of RBOs on a three-year cycle. For an independent MSO with several clients, the number of audits is increasing into the hundreds. MSOs are hiring and training compliance staff as quickly as possible. While Medicare Advantage audit protocols are well-known and standardized, newer approaches in Medi-Cal are not. Audit protocols, content and format change constantly. In this environment, compliance is very challenging. APG has committed to assisting our members and their MSOs by working with various consultants and health plans to develop and vet a model structure for Medi-Cal compliance competency.

As APG developed the Standards of Excellence Program in the mid-2000s as a best-practices guide to aspiring delegated model groups to develop the "systemness" necessary to coordinate patient care, we are developing this new program to raise the level of compliance competency across the spectrum of organizations that operate in California. The "checklist" provides the suggested best practice elements to demonstrate an adequate level of staffing, experience, and organizational integrity to function well in Medi-Cal. See Appendix, Item A, Code of Conduct and Audit Compliance Capabilities for APG Members.

On the other hand, regulators need to understand that due process, and fairness need to be an integral part of their enforcement activities and protection of the public. When risk-bearing organizations are audited, there should always be provision made for the organization to present its side of the story.

Conclusion

There are significant barriers to entry into the market for providers willing to become risk bearing organizations, and there has always been a strong contingent of physicians across the nation that oppose risk-based payment and managed care. Ultimately, physicians do not have to accept financial risk, and many would prefer to continue under a fee-for-service system. But study after study shows that when physicians accept financial risk for the outcome of their patient population they perform better and deliver value to the healthcare system. This is no doubt why Medicare has moved away from pure fee-for-service payment to the MACRA model of value-based payment.

But It is becoming increasingly difficult for providers to accept risk in this market environment, ironically at just the point in time when risk-bearing models are becoming nationally recognized as "the future" of American healthcare. Not because they can't manage the financial risk, but because they can't keep up with the regulatory environment under which they must operate as a risk-bearing organization. Independent MSOs provide the necessary administrative infrastructure for new organizations to enter the market, so that they can function in a compliant manner and focus on the performance of their physicians. APG is committed to educating policymakers on the importance and value of this model in the California healthcare system.

Appendix

Table 1: Independent MSO Market Segment in California

Item A: Code of Conduct and Audit Compliance Capabilities for APG Members

Table 1

California Independent MSOs

Name	Number of Groups Managed	Enrollment Range
Advanced Medical Management, Inc.	6	180,000 -250,000
Agilon/Primary Provider Management Co, Inc	3	300,000 – 399,999
Alpha Medical Management, LLC	3	25,000 – 49,999
Coast Healthcare Management, LLC, Sub of Tenet Healthcare	5	100,000 – 149,999
Conifer Value-Based Care, LLC, Sub of Tenet Healthcare	9	700,000 - 850,000
EPIC Management, L.P.	6	100,000 – 149,999
HealthSmart Management Services Organization, Inc.	10	100,000 – 149,999
Managed Care Systems, LLC	3	50,000 – 99,999
McKesson Business Performance Services	2	5,000 – 9,999
Med3000, Inc dba McKesson Business Performance Services-California	5	100,000 – 149,999
MedPoint Management	14	800,000 – 950,000
MSO, Inc of Southern California/Vitalinks, Inc	5	25,000 – 49,999
Network Medical Management, Inc	4	500,000 – 599,999
North American Medical Management California, Inc, Affiliate of OptumHealth Holdings, LLC	3	200,000 – 299,999
Pacific Partners Management Services, Inc/HCA Physician Services	2	25,000 – 49,999
Physicians DataTrust, Inc	3	25,000 – 49,999
PremierOne Plus MSO	6	<5,000
ProCare Physician Services MSO, A Partnership	3	<5,000
Prospect Medical Systems, Inc	7	200,000 – 299,999
S and S Management, Inc	3	<5,000
Southern California Physicians Managed Care Services, Inc	4	50,000 – 99,999
Sutter Connect dba Sutter Physician Services	7	200,000 – 299,999

Source: Cattaneo & Stroud, 2017

Item A

Code of Conduct and Audit Compliance Capabilities for APG Members

Code of Conduct and Audit

Compliance Capabilities for APG Members

Overview

1. Landscape:
   a. Increased regulatory scrutiny over the delegated model
   b. Increased audit activity from plans/payers
   c. Need for groups, IPAs, and MSOs to have high-functioning compliance programs

2. Recommendations:
   a. Complete the proposed checklist for your Compliance function
   b. By using this checklist, assess your Compliance function
   c. Be prepared to demonstrate your 'audit-and-delegation-oversight readiness' to current payers and future payers in highly fluid environment

Checklist: Complete for Effective Compliance Program

Function	Detail		Responsible party(ies)		Documented P&P		Impacted Departments		
	Exec Team knows its elements	Board knows core elements	Lead	Support	Yes	No	Dept	Dept	Dept
A. Compliance Program in General									
1. Implement the 7 elements of a Compliance Program									
2. Designate a Compliance & Privacy Officer									
3. Establish an Annual Compliance Work Plan									
4. Secure appropriate reporting to CEO and Board									
5. Implement a system to receive, record, respond to, and track compliance suspected non-compliance or potential FWA									
6. Implement a system for prompt response to compliance issues as they're raised, investigate potential issues, and correct issues thoroughly to reduce the potential for recurrence.									
7. Publicize disciplinary standards through the implementation of procedures which encourage good faith participation in the compliance program.									
8. Establish a Compliance Committee									
9. Hire appropriate staff for functions									
10. Train the staff that you have hired									
11. Maintain knowledge of current regulatory changes and interpretation of laws									

12. Establish a process to communicate compliance information throughout the organization (e.g. reporting information, regulatory communications).									
13. Establish P&P process for ownership + management									
14. Evaluate the effectiveness of the compliance program on a periodic basis									

Checklist: P&P Checklist

Checklist for minimal P&P	Responsible for SMEs		Impacted Departments		
	Lead	Support	Dept	Dept	Dept
1. Compliance Program – key elements					
2. Fraud, Waste & Abuse Program (can be incorporated in to compliance program)					
3. Code of Conduct					
4. HIPAA and Security (can live w Privacy Officer, etc., but needs a nexus to Compliance					
5. Compliance Committee: governance, structure, role					
6. Policy Committee: governance, structure, role					
7. Training: Compliance, HIPAA, Security, Code of Conduct, reporting					
8. Reporting on compliance issues					
9. Establish a Zero tolerance for Intimidation and/or Retaliation Policy					
10. Notice of deficiencies, corrective action plan(s) (CAPs), CAP management, and enforcement					
11. Monitoring and internal auditing					
12. Payer and regulatory reporting and communications (may live with SMEs but needs a nexus to Compliance)					
13. Exclusion reporting					
14. Conflict(s) of interest					
15. Records retention					
16. Contract compliance (may live with Provider or elsewhere but needs a nexus to Compliance)					

Checklist: Complete for Effective Compliance Program

Function	B. Monitoring and Internal Audit								
	Detail		Responsible party(ies)		Documented P&P		Impacted Departments		
	Exec Team knows its elements	Board knows core elements	Lead	Support	Yes	No	Dept	Dept	Dept
1. Create a Monitoring and Internal Audit function									
2. Perform a risk assessment to guide the audit strategy for the year									
3. Create an annual work plan for internal audit based on the results of the risk assessment									
4. Establish reporting of the risk assessment and the audit plan to Board and Compliance Committee									
5. Hire staff knowledgeable in operations contractual & regulatory requirements that are dedicated to the internal audit function									
6. Train the staff that you have hired									
7. Establish P&P process for ownership + management									
8. Execute and complete annual audit plan									
9. Routinely report audit activities and findings to the Compliance Committee and the Board									
10. Monitor and validate implementation of corrective actions									
11. Screen employees for eligibility to participate in State and Federal healthcare programs prior to hire and monthly thereafter									

Checklist: Complete for Effective Compliance Program

Function	Detail		Responsible party(ies)		Documented P&P		Impacted Departments		
	Exec Team knows its elements	Board knows core elements	Lead	Support	Yes	No	Dept	Dept	Dept
C. Fraud, Waste, and Abuse									
1. Create a Fraud Waste & Abuse Program									
2. Establish reporting to Board and Compliance Committee									
3. Hire appropriate staff for FWA									
4. Train the staff that you have hired									
5. Establish P&P process for ownership + management									

Checklist: Complete for Effective Compliance Program

Function	Detail		Responsible party(ies)		Documented P&P		Impacted Departments		
	Exec Team knows its elements	Board knows core elements	Lead	Support	Yes	No	Dept	Dept	Dept
D. Code of Conduct and Training									
1. Create or ensure creation of Code of Conduct									
2. Ensure that all employees agree to Code of Conduct									
3. Secure acknowledgement of confidentiality statement upon hire and annually thereafter									
4. Train on the Code of Conduct upon hire and annually thereafter									
5. Train on HIPAA and Security prior to PHI access and annually thereafter									
6. Train Fraud, Waste, and Abuse upon hire and annually thereafter									
7. Train on core elements of Compliance Program upon hire and annually thereafter									
8. Train on how to report Compliance issues									
9. Ensure the Board receives training (Items 3-7 listed above), including understanding their responsibility for oversight of the compliance program.									