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Hands-On or Hands-Off: Balancing Monitoring and Oversight at the State Level

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The transition away from fee-for-service reimbursement to value-based payment models is accelerating rapidly across the United States as the Triple Aim takes hold. We have observed several lessons learned during our careers that provide a framework for this transition.

As physician groups and integrated delivery systems evolve into risk-based payment arrangements with government and commercial payers, regulatory monitoring and oversight is a necessary component to ensure program integrity, compliance, and the welfare of members served by managed care organizations. Many states lack the necessary infrastructure to license and/or monitor provider entities that are moving into risk-based payments. As the Centers for Medicare & Medicaid Services (CMS) enables more organizations to form alternative payment models (APMs) under the Medicare Access and CHIP Reauthorization Act (MACRA), some form of state-level oversight infrastructure will be needed.

Whether the health plan and/or contracted provider risk-bearing entity (RBE) is a for-profit or not-for-profit entity, they must maintain sufficient administrative capacity to ensure efficient and cost-effective operations. Additionally, they must maintain adequate financial reserves to protect members, providers, and

It is not easy to regulate health plans and RBEs these days. We are talking about large and complex organizations with hundreds of thousands or millions of members, participating in multiple lines of business, with different methods of operation and computer systems, and working with a variety of affiliated entities and/or outsourced vendors to meet their obligations. For a state regulator to have any reasonable understanding of what is happening inside a health plan or RBE, they must be engaged year-round and make a concerted effort to get into the heart of the organization to see how the licensee is actually operating.

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Whether you love it or hate it, the Affordable Care Act (ACA) has resulted in millions of newly insured lives coming into the managed care system. And, with the surge in enrollment, significant strains have been placed on the administrative structures of most managed care organizations. It is not uncommon to see longer claims turnaround times; higher error rates on paid claims, more provider disputes, late claims with interest and penalties due, grievances, and appeals; difficulty managing the high volume of complex cases; staffing challenges; and, from a financial perspective, difficulty in estimating incurred but not reported (IBNR) claims liability.

None of these strains are beyond the health plan or RBE's ability to correct over time, and most are, in fact, moving quickly to restore compliance. However, not all health plans and RBEs have the same knowledge and expertise. Monitoring and oversight by regulatory agencies is necessary to ensure that all licensees are held to the same standards, and that each is working diligently to resolve areas of noncompliance while striving to improve patient care and operational efficiency and effectiveness.

We fully recognize that managed care organizations already believe there is too much regulatory oversight and feel like they are drowning at times under audits by CMS, state regulatory agencies or, in the case of RBEs, their health plan partners. We agree the number of audits often is too many, and some effort needs to be made to reduce the burden on the health plans and RBEs while producing the kinds of audit results necessary to ensure stakeholders' interests are protected. Focused audits of the claims or utilization management departments, and annual independent financial audits are helpful and provide useful information. Yet all these audits have limited value when trying to understand the organization and interdepartmental dependencies at a detailed operational level and attempting to identify and address underlying systemic issue(s) that may be at the root of many noncompliance issues.

For those who say it's not the role of government to run the managed care organization or tell them what to do, we say, you are absolutely right. Regulators are not supposed to run the businesses they regulate; rather, they exist to ensure compliance with laws, rules, and regulations, and to make recommendations for improvement. However, to those critics who advocate for less regulatory oversight ("hands off"), you need to live through a failure or two to understand the potential risks and impact of a business failure or series of repeated process failures. Thousands of members have been or could be thrown into a state of uncertainty because their care has been disrupted, providers suddenly refuse to provide care due to non-payment, or they've lost confidence in a system that is supposed to protect them.

Although the market is experiencing fewer health plan or RBE failures than in previous years, largely due to industry consolidation, we have all seen or heard about failures of large institutions. Allowing a bank or an automobile manufacturer to fail or to receive a bailout is a matter of public policy, but letting a large health plan or RBE fail is a completely different matter. That has the potential to cost lives or at least impair the health and well being of thousands of members, which is something that regulators must not allow to happen in the public interest. Waiting for a failure to occur and then responding to the fallout that will invariably happen (i.e., Why didn't you know? Why didn't you do more or take action sooner?) is not where regulators want to end up. The only real answer is for regulators to have more hands-on involvement throughout the year—and it has to be more than cursory involvement to be meaningful.

A short list of options is available to states considering how to implement regulatory oversight of a growing industry of risk-bearing entities in a value-based payment environment:

- All managed care functions (licensing, monitoring and oversight, auditing, reporting and enforcement) should be consolidated under one agency. Silos only increase the probability that monitoring and oversight activities will be less than optimal.

- State regulatory teams need educated and trained staff that understand the managed care business and possess specific levels of expertise in how managed care organizations operate.

- Regulatory standards must be enforced consistently across all licensees in order to ensure program integrity and consistency in enforcement actions.

- On-site audits need to be more comprehensive (e.g., plan-wide) and, at least periodically, include a deep dive into the plan's entire operation, so there is a more complete understanding of its administrative capacity, staffing and financial strengths, and weaknesses. Joint audits are preferred over separate financial and medical audits. Not only is it less intrusive on the licensee, a joint audit enables examiners to confer with each other during the exam, which usually results in a better audit.

- Regulators should allow health plans to consolidate their compliance and oversight activities to prevent the need for every health plan to audit every RBE every year. Duplication of effort is expensive, time consuming, and a waste of valuable resources. Audit/compliance exceptions, when found, should lead to a universal corrective action plan (CAP) that all plans can monitor to ensure compliance.

- Although regulators ultimately hold health plans accountable for the financial solvency and administrative capacity of their delegated entities, regulators need to look more closely at RBEs too, because through delegation RBEs are often contractually obligated to provide many or most of the same services the health plan would normally provide. In our experience, there has been a wide variation in the level of administrative competence at the RBE/management services organization (MSO) level. RBEs also tend to have lower enrollment levels and are therefore subject to higher risks than their health plan partners, which can lead to a higher rate of failure.

The healthcare industry has embraced the Triple Aim: improvement in the health of populations, improvement in the experience of healthcare, and lower per capita costs. To ensure success, regulators need to play an important role in making the Triple Aim a reality—that is, by making sure licensees do what is necessary to ensure that the health of their enrolled populations improves, members see improvement in their individual experiences of healthcare, and health plans and RBEs strive to find ways to operate in an efficient and cost-effective manner and ensure their financial viability going forward.

Our purpose in writing this article is to stimulate discussion about regulatory oversight and to highlight ways in which state regulatory agencies can help ensure health plans and RBEs in their states perform at optimal

levels. The three of us have worked through the impacts of failed entities during our careers, including shutdowns and turnarounds. We have collaborated on strategies to save troubled entities, and managed transitions when insolvency couldn't be remedied. Each of us remains enthusiastic about health reform in the U.S. An effective oversight and monitoring program will also ensure that managed care continues to build trust among all stakeholders and that quality and cost efficiency remain the driving forces for change.

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