110.2 - Delegation Requirements

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The organization oversees and is accountable for any functions or responsibilities that are delegated to other entities.

With certain restrictions indicated below, an organization may, by written contract, delegate any activity required under or governed by these standards to another entity. However, an organization entering into a Medicare contract remains accountable to CMS or the State for performance of any such delegated function. It is the sole responsibility of the organization to ensure that the function is performed in accordance with applicable standards. (Note that this standard is not meant to imply that the organization is legally liable for the actions of its subcontractors. For example, in cases of malpractice any such liability is established by State or local law.)

Special note must be made of "carve-out" arrangements, under which a managed care organization contracts with an entity to assume entire responsibility for a given type or category of service and delegates to that entity a broad range of basic management functions. Such contracts are most common for mental health and substance abuse services, although some organizations use similar arrangements for prescription drugs, home health care, or other types of services. These arrangements are conceptually no different from those under which an organization capitates a single medical group to provide all physician and related ambulatory services and delegates management of those services to the group. Although the latter arrangements are never spoken of as "medical carve-outs," they are functionally comparable to "mental health/substance abuse carve-outs." The contractor assumes entire responsibility for management of a defined portion of the overall benefit package. Just as medical group contracts have never diminished the basic accountability of the organization directly contracting with Medicare or Medicaid, so with mental health or other carve-outs. The prime contractor remains wholly accountable for the activities of its subcontractors.

Because of the wide variety of organizational structures and contractual arrangements, it is difficult to develop simple guidelines for the review of delegated activities. In any given situation, the review methodology to be adopted should be that which is least burdensome for reviewers and for the organization, yet which provides positive assurance that the activity in question is being performed in compliance with these standards. For example, credentialing of providers might occur in several different ways:

1. The organization itself verifies the credentials of individual providers affiliated with its subcontractors. Review would focus directly on the organization's performance of this function;

2. An organization contracts with one or more independent physician groups, each of which is expected to verify the credentials of each affiliated provider. It would be impractical for a CMS or State reviewer to review compliance by the independent contractor(s). Instead, the organization itself must document that it has periodically reviewed the performance of each contractor, for example by verifying that all required credentialing information is present in a sample of each contractor's provider records; or

3. An organization contracts with a single independent credentialing verification organization (CVO) to collect information about providers. The CVO, and not the organization, maintains documentation of verification of credentials from primary sources. If a single CVO provided services to multiple organizations in a State, a

State Medicaid agency might review the CVO itself and deem in compliance all organizations that contracted with the CVO. Alternatively, the State might accept the findings of an independent body that accredits CVOs. For the purposes of Medicare, however, CMS does not at this time review CVOs or accept external accreditation of CVOs. It would, therefore, expect the organization to document that it has monitored the CVO's performance, again through a review of a sample of practitioner records. (Similarly, the organization would be required to review the credentialing performance of any "carve-out" contractor, such as a national managed behavioral health care organization.)

This example illustrates that the variety and complexity of contracting arrangements makes it impractical to suggest a uniform method for review of delegated functions. As part of the advance preparation for on-site reviews, the reviewer and the organization should negotiate the most expeditious procedure. However, the burden of documenting a delegate's compliance with applicable standards ultimately rests with the organization. It is especially important to identify instances in which a delegation has been made implicitly. For example, a contract with a medical group may hold the group responsible for providing or arranging for a wide range of ambulatory services in return for a fixed monthly capitation payment. The group is left to develop its own procedures for approving requests for referral services by its own primary care providers. If so, the utilization management function has been delegated, and the organization must ensure that the group complies with the standards for that function, including standards related to requests for expedited review.

The following specific requirements apply to all delegated functions:

- Written arrangements must specify delegated activities and reporting responsibilities;
- The organization evaluates the entity's ability to perform the delegated activities prior to delegation. The organization must document that it has approved the entity's policies and procedures with respect to the delegated function. It also must verify that the contractor has devoted sufficient resources and appropriately qualified staff to performing the function; or
- The performance of the entity is monitored on an ongoing basis and formally reviewed by the organization at least annually. The organization must have written procedures for monitoring and review of delegated activities. The nature of ongoing monitoring may vary according to the organization's past experience with the delegate and with the nature of the delegated activity. In the areas of grievance processing or utilization management, for example, monitoring may be more or less continuous, in as much as decisions by the delegate may be appealed to the organization. However, the organization must periodically verify that the delegate is in fact forwarding requests for reconsideration, and that its statistical or other reporting on these processes is accurate. In other areas, such as credentialing, annual review of the delegate's activities may be sufficient, particularly if the organization has ascertained in the past that the delegate is performing the activity properly.

The annual evaluation should be a comprehensive assessment of the delegate's performance, including both compliance with applicable standards and the extent to which the delegate's activities promote the organization's overall goals and objectives for the delegated function. If any problems or deficiencies are identified, the evaluation must specify any necessary corrective action and include procedures for assuring that the corrective action is implemented.

The organization must ensure that monitoring of delegates is carried out by staff of the organization who are qualified to assess the delegates' activities. For example, an organization that has delegated authorization of mental health and substance abuse services to an entity must use appropriately credentialed professionals to review the entity's authorization decisions.

The following requirements apply:

- Written arrangements must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily;
- Written arrangements must further specify that either:
    - The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization;
    - The credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis; or
    - The policies and procedures that an MA organization develops for its related entity, contractor, subcontractor, first-tier and downstream entities must state that these entities must comply with all applicable Medicare laws, regulations, and CMS instructions;
- If the organization delegates selection of providers to another entity, the organization retains the right to approve, suspend, or terminate any provider selected by that entity; and
- Written arrangements must specify that the performance of the parties is monitored by the MA organization on an ongoing basis.