Gabeo.ai | WHITE PAPER

PRESENTED AT
AMERICA'S PHYSICIAN GROUPS

CONFIGURATION INTEGRITY IN DELEGATED CARE

Shining a Light *into the Darkness*

How configuration errors damage capitated and delegated care.

A **Gabeo.ai** White Paper · May 2026

AUTHORS

Michael Riley
Co-Founder & CPO, Gabeo.ai

Octavio Campos
Director of Operations, Guidant Health

Michael Skolnik
Healthcare Executive & Educator

Michelle Glatt
Healthcare Operations Executive

CONTENTS

What's inside

Who This Paper Is For

This paper is written for health plan leaders, IPA leaders, MSO leaders, medical group executives, ACO operators, provider relations teams, claims leaders, finance leaders, and technology leaders who are responsible for making delegated care work in the real world.

The core issue is simple. Contracts describe the model. Systems execute the model. If the contract and the system do not match, the organization is not really managing delegated care. It is managing a version of delegated care that may be financially wrong, operationally confusing, and invisible to leadership.

In capitated delegated care, the Division of Financial Responsibility, or DOFR, is not a legal exhibit that sits behind the agreement. It is the operating map for the financial relationship between the health plan, the IPA, the MSO, and the provider network. It determines who pays, who manages, who authorizes, who reports, and who carries the financial consequence when something goes wrong.

That is why configuration integrity has to be treated as risk infrastructure. It is not only a claims problem. It is a delegated care problem, a financial problem, a provider relations problem, a quality problem, and ultimately a patient access problem.

This paper shows how configuration integrity can be made measurable with real contracts, real claims, real configuration data, and a practical validation process that gives plans, IPAs, and MSOs a clearer way to manage delegated risk.

Executive Summary

Healthcare runs on contracts, but healthcare gets paid through configuration. Delegation agreements, DOFR schedules, fee schedules, benefit rules, provider files, authorization rules, capitation deductions, reserves, and carve outs all have to be translated into system logic. Once that logic is loaded, the claims system does what it is told to do. The system does not know what the contract intended unless the contract has been translated correctly.

The problem is not that people are careless. The problem is that the work is too complex for manual review alone. A single delegated arrangement may include professional risk, institutional carve outs, emergency room rules, outpatient facility rules, specialist payment rules, drugs, durable medical equipment, ancillary services, prior authorization ownership, network exceptions, and multiple effective dates. Every amendment creates another opportunity for the contract and the system to drift apart.

DOFR errors are especially dangerous because many of them do not look like errors. A claim can adjudicate cleanly, pay on time, and still land in the wrong financial bucket. The provider may be paid, but the wrong party may have carried the expense. The capitation deduction may look normal, but the underlying rule may be wrong. The joint operating committee may see a trend, but not the configuration defect that is causing it.

This is what makes the problem so damaging in capitated delegated care. The wrong configuration does not only mispay a claim. It distorts the economic model. It changes surplus. It changes medical loss reporting. It changes plan and IPA trust. It changes how providers experience the network. It can also change whether patients can get timely access to care because providers who are not paid correctly eventually push back, limit access, or leave.

The market is making the risk larger. CMS reported that 14.3 million Medicare beneficiaries were aligned to Accountable Care Organizations in January 2026. KFF reported that Medicare Advantage enrollment reached more than 35 million people in February 2026, with Special Needs Plans accounting for most of the recent growth. These models depend on delegated accountability, accurate financial rules, and strong operating discipline.

The answer is not to rely on reconciliation after the damage is done. Reconciliation is needed, but it is not a strategy. The answer is configuration integrity. That means building a process that

can read the contract, structure the rule, compare it to the system, replay claims, quantify the exposure, assign ownership, and keep monitoring after the fix.

A configuration integrity layer is needed for effective delegated care. The value is practical. Connect what the contract says, what the system did, which claims show the gap, what dollars are involved, who owns the correction, and how future claims can be prevented from repeating the same error.

What Has To Be Fixed

Delegated care fails when the economic responsibility in the contract is not the same as the economic responsibility in the claims system, the capitation process, the provider file, the authorization workflow, and the operating reports. The fix is not more meetings. The fix is a source to system validation process that proves whether delegated care is being executed the way it was contracted.

- The DOFR must be turned into operational rules that can be tested, audited, and monitored.
- The plan and the delegated entity must use the same version of the contract, amendments, effective dates, carve outs, and service categories.
- Claims should be tested before go live and then monitored after go live.
- Capitation deductions, surplus calculations, reserves, and provider payments need to tie back to validated configuration rules.
- The joint operating committee should look at root cause, dollar exposure, provider abrasion, patient access risk, owner, and closure status.
- AI can help, but only if it is connected to real configuration extracts, real claims, real provider files, real authorization rules, and real capitation logic.
- The validation needs to be based on actual delegated care operations, not on a generic technology demonstration.

SECTION 01

Why Capitated Delegated Care Changes the Problem

In a simple fee for service contract, configuration error usually affects payment accuracy. In capitated delegated care, configuration error affects the transfer of risk. That is a much larger problem.

The health plan remains accountable to CMS, state regulators, members, benefits, grievances, access standards, network adequacy, Star Ratings exposure, and quality performance. The plan may delegate claims payment, utilization management, or financial risk, but it does not delegate away accountability.

The IPA or risk bearing medical group accepts responsibility for a defined portion of the care. It depends on accurate capitation, accurate deductions, accurate carve out logic, accurate claims reports, and a clear understanding of what it owns and what the plan owns.

The MSO often becomes the operating engine. It translates contracts into system rules, manages claims processes, runs utilization workflows, supports provider relations, produces reporting, and helps leadership understand financial performance. If the MSO is operating on incorrect configuration, the whole delegated model becomes unstable.

The provider network is where the damage becomes visible. Providers do not care whether the problem started in the contract, the DOFR, the claims platform, the provider file, the authorization matrix, or the capitation reconciliation. They care that they did the work and did not get a clear or correct payment outcome.

Patients experience the system as one integrated promise. They do not separate plan operations from IPA operations from MSO operations. When the network gets frustrated, access weakens. When access weakens, patients feel it.

The Delegated Care Operating Chain

The plan owns regulatory accountability, benefits, oversight, Star Ratings exposure, network performance, and member experience.

The IPA or medical group owns the risk pool, provider relationships, medical expense performance, access to care, and the local care model.

The MSO owns much of the operating reality, including claims processes, authorization workflows, provider file maintenance, reporting, and financial reconciliation.

The providers deliver the care and expect clear rules, fair payment, and fast answers when claims do not pay correctly.

The member is affected by all of it through access, trust, timeliness, coordination, and satisfaction.

SECTION 02

The Core Problem Is The Contract To Configuration Gap

The contract is a legal document. Configuration is the operating truth. The system does not know what leadership intended. It only knows what was loaded. If the wrong rule is loaded, the system can process claims efficiently and still be financially wrong.

The problem is not limited to the DOFR. It includes every rule that turns the contract into operational reality.

Financial responsibility: which party pays the claim and which party takes the medical expense.

Utilization management ownership: who authorizes, who denies, who redirects, and who receives the provider call.

Claims adjudication logic: codes, modifiers, revenue codes, place of service, diagnosis logic, provider type, specialty, and effective date.

Provider file logic: which provider is in network, which tax identification number applies, which specialist belongs to which arrangement, and which facility affiliation controls the claim.

Benefit design: co pays, coinsurance, deductibles, supplemental benefits, carve outs, and plan specific exceptions.

Capitation and settlement logic: deductions, risk pools, reserves, shared savings, stop loss treatment, and final reconciliation.

Reporting logic: whether the claim is reported in the correct financial category and whether leadership is seeing the right version of performance.

A DOFR error is often invisible because the claim can process normally. That is why it is dangerous. The wrong party can pay the claim, the wrong entity can absorb the expense, the wrong report can be produced, and no one may know until months later.

SECTION 03

High Risk Failure Points

The most common delegated care failures are not theoretical problems. These are the errors that make capitation performance look worse than it is, make plans and IPAs distrust each other, and make providers lose confidence in the network.

Wrong party payment: the plan pays a claim that should have been delegated, or the IPA absorbs a claim that should have remained with the plan.

Wrong rate payment: the correct party pays, but the wrong fee schedule, case rate, per diem, or amendment is used.

Wrong carve out logic: a service that should be excluded from capitation is treated as delegated expense, or a delegated service is treated as plan responsibility.

Wrong effective date: a new amendment is loaded late, loaded early, or loaded in one system but not another.

Wrong authorization owner: the claim is financially assigned to one party, but the authorization workflow points to another party.

Wrong provider mapping: a claim routes incorrectly because the provider record, specialty, place of service, tax identification number, or facility relationship is wrong.

Wrong capitation deduction: the deduction is taken but the underlying rule does not match the DOFR or the amendment.

Wrong reporting: the claim may pay correctly but still appear in the wrong report, which damages medical loss reporting, reserves, surplus, trend analysis, and leadership decisions.

Wrong operating response: teams fix one claim but do not fix the rule that produced the error. The same problem then repeats month after month.

SECTION 04

The Damage Is Larger Than The Claim

Health plan impact

For a health plan, configuration errors create overpayments, underpayments, capitation disputes, provider disputes, inaccurate delegation oversight, and avoidable regulatory risk. A plan can think it has delegated risk cleanly, but if the rules are wrong, the plan may still be carrying expenses it meant to delegate or pushing expenses to the IPA that should have stayed with the plan.

The Star Ratings connection is indirect, but it is real. A configuration problem does not automatically reduce a Star Rating. Payment confusion can drive provider abrasion. Provider abrasion can affect access. Access problems can affect member experience, complaints, retention, and quality performance.

IPA and MSO impact

For an IPA or risk bearing medical group, DOFR misconfiguration can quietly erode the economics of the model. Claims that should be plan responsibility may hit the IPA expense pool. Carve outs may be missed. Capitation deductions may be wrong. Surplus may be understated. Provider disputes may pile up. The organization may look operationally weak when the deeper issue is a contract to configuration defect.

For the MSO, the damage is operational and reputational. Claims teams, provider relations teams, utilization management teams, finance teams, and executives all end up working around the same unresolved defect. The MSO becomes the place everyone calls when the system does not make sense.

Provider impact

Providers feel the pain first. Claims bounce, payments delay, recoupments appear, denials get resubmitted, and no one gives a clear answer. This creates provider abrasion. Over time, providers may stop taking new members, resist plan growth, request carve outs, or leave the network.

Patient impact

Patients do not experience configuration failure as a technical problem. They experience it as confusion, delayed access, narrow specialist availability, longer wait times, and a system that

does not seem coordinated. The financial error becomes an access problem.

SECTION 05

Why Current Approaches Fall Short

The single expert model is fragile

Many organizations rely on one or two people who understand how the DOFR, claims platform, provider file, benefits, capitation, and reconciliation logic fit together. That person becomes the control point. If they are right, the organization is safe. If they are wrong, the organization may not know. If they leave, the knowledge leaves with them.

Legacy systems execute rules, they do not validate intent

Claims systems can process large volumes of claims. That does not mean the rules are right. If the wrong rule is loaded, the system will execute the wrong rule with speed and consistency. Automation without validation simply makes the mistake repeat faster.

Reconciliation is necessary, but it is not a strategy

Reconciliation happens after the money has moved, the reports have been produced, the providers have been frustrated, and leadership has already reacted to distorted data. It can recover some money, but it does not create a reliable operating model.

Sampling does not see the full rule problem

Traditional audits often test samples. Samples can identify symptoms. They may not find the full operating rule that is producing the error across thousands of claims. Delegated care needs full pattern detection, not only sample review.

SECTION 06

The Path Forward Is Configuration Integrity

The industry has to stop treating configuration as a clerical task and start treating it as risk infrastructure. In capitated delegated care, configuration determines the economics of the relationship. It deserves the same seriousness as actuarial pricing, contract negotiation, network adequacy, and regulatory compliance.

AI enabled configuration intelligence does not replace the people who know the contracts and the systems. It gives them a validation layer, an audit trail, and a way to see what no individual person can see across all claims, all amendments, all provider files, and all effective dates.

- Read and structure the contract, DOFR, amendments, fee schedules, benefit rules, carve outs, authorization rules, and effective dates.
- Compare expected rules against actual claims, authorization, provider, benefit, and capitation configuration extracts.
- Replay historical claims against the expected rule set to show what should have happened and what actually happened.
- Monitor live claims and identify configuration defects before they become a large financial pattern.
- Quantify exposure by plan, IPA, provider, service category, effective date, and financial responsibility category.
- Create an audit trail so the plan, IPA, MSO, and provider relations team can see what was found, who owns it, what changed, and when the issue closed.
- Produce an operating report that can be used in joint operating committees, not just a technical report that only claims analysts can read.

What A Credible Technology Has To Prove

This point matters. A serious configuration integrity platform has to connect the contract to real configuration, real claims, real financial responsibility, and real operational ownership.

- It must show the source document, the expected rule, the actual system behavior, the claim examples, and the dollar impact.
- It must separate configuration error from coding error, eligibility error, provider file error, authorization error, claims processing error, and contract ambiguity.

It must include human review because delegated care has judgment, exceptions, historical practices, and plan specific interpretations.

It must protect protected health information and follow clear data security rules.

It must produce operational fixes, not only analytics.

SECTION 07

How Gabeo Makes Configuration Risk Visible

For a health plan, IPA, or MSO, the question is not whether configuration integrity sounds important. The question is whether the organization can see the gap between the contract, the system, the claim, and the financial result. Gabeo.ai is built to make that gap visible.

Most delegated care disputes begin with different parties looking at different pieces of the truth. The plan may be looking at the claim payment. The IPA may be looking at the capitation deduction. The MSO may be looking at the DOFR rule. Provider relations may be looking at the complaint. None of those views are enough by themselves.

Gabeo connects those pieces into one evidence layer. It ties the DOFR rule, the configured rule, the claim line, the paid party, the provider file, the authorization rule, the capitation deduction, the dollar impact, and the owner of the correction. That is what turns configuration integrity from a concept into an operating tool.

For prospective customers, the value is practical:

- Gabeo translates DOFR provisions, amendments, carve outs, effective dates, and authorization rules into testable operating rules.
- Gabeo compares expected financial responsibility against actual claims system behavior.
- Gabeo identifies wrong party payment, incorrect carve out treatment, provider file mismatches, authorization ownership mismatches, and settlement logic problems.
- Gabeo quantifies recoverable dollars and future prevention value by plan, IPA, provider, service category, and effective date.
- Gabeo separates true configuration defects from contract ambiguity, coding issues, eligibility issues, provider file issues, and workflow issues.
- Gabeo creates a joint operating committee package that gives the plan, IPA, MSO, and provider relations team the same fact base.

The result is a better conversation between the plan and the delegated entity. Instead of debating whether a claim is wrong, both sides can see the rule, the claim behavior, the financial impact, the root cause, and the fix. The discussion moves from blame to correction. It also moves from one claim at a time to a pattern that can be fixed before it repeats.

This is the practical test a prospective customer should expect. The value is not in broad promises. The value is in showing, with real customer data, where the contract and the system

do not match, what the mismatch costs, and how the customer can prevent the same problem from recurring.

A credible validation does not require every file in the enterprise. It requires the right files for one defined delegated arrangement. The work can start narrow, but it has to be real enough that the results can guide a real operating decision.

SECTION 08

The Data Needed For A Credible Validation

Contract and rule data

Executed delegation agreement.

Current DOFR and prior DOFR if the lookback period crosses an amendment date.

All amendments, side letters, carve outs, and effective date changes.

Fee schedules, case rates, per diems, and plan specific rate exceptions.

Benefit summaries and plan specific cost share rules when those rules affect adjudication or provider payment.

Authorization matrix showing who owns review, approval, denial, redirection, and provider communication.

System and configuration data

Claims system configuration extracts for the selected contract and delegated entity.

DOFR rule tables or equivalent service category mappings.

Code group logic for CPT, HCPCS, ICD 10, revenue code, modifier, place of service, and provider specialty rules.

Provider master and network files, including tax identification number, National Provider Identifier, specialty, facility affiliation, network status, and effective dates.

Fee schedule tables and effective date history.

Capitation deduction logic, reserve logic, risk pool logic, stop loss treatment, and settlement files if applicable.

Claims and operating data

Six to twelve months of paid, denied, adjusted, reversed, and reprocessed claims for the selected delegated arrangement.

Claim line detail with service date, paid date, provider, place of service, code, modifier, allowed amount, paid amount, denial reason, adjustment reason, and paid party.

Authorization data where authorization ownership is part of the financial responsibility rule.

Provider dispute logs, call center themes, and provider relations escalation files when available.

Capitation payments, capitation deductions, surplus or deficit reports, reserve reports, and reconciliation workpapers.

Joint operating committee issue logs if the plan and delegated entity already track recurring payment or DOFR problems.

Security and data control

Because this work touches claims and potentially protected health information, the process has to include clear controls. The validation uses the minimum necessary data, defined user access, secure file transfer, an audit trail of who touched the data, and clear rules for retention and destruction. That discipline matters to plans, IPAs, MSOs, and compliance leaders.

SECTION 09

A Strong Pilot Is Narrow, Practical, and Evidence Based

The first pilot does not need to solve every contract and every system. It needs to prove the model with one real delegated arrangement where the plan, IPA, and MSO can see the same facts and agree on the same operating truth.

Select one health plan contract, one delegated IPA or medical group, and one defined period of claims history.

Load the DOFR, amendments, fee schedules, benefit rules, provider file extracts, authorization rules, and capitation deduction logic.

Replay twelve months of claims against the expected rule set.

Classify findings by root cause, including configuration error, contract ambiguity, provider file issue, authorization mismatch, and claims processing issue.

Quantify the dollar exposure and separate recoverable dollars from future prevention opportunity.

Identify the top rules causing the most financial and operational damage.

Create a joint operating committee report that shows the problem, the owner, the fix, the expected savings, and the next action.

Use the pilot to decide whether to expand, adjust, or stop. The decision is based on evidence, not enthusiasm.

What The Gabeo Pilot Proves

How many claims followed the expected DOFR rule and how many did not.

Which service categories created the largest financial exposure.

Which provider file or contract rules created the largest routing problem.

Which capitation deductions or settlement items did not match the expected rule.

Which issues were true configuration defects versus contract ambiguity or operational workflow defects.

Which findings can be fixed immediately and which require contract clarification.

Which future claims can be prevented from repeating the same error once the rule is corrected.

How much provider abrasion can be reduced by fixing the root cause instead of fighting one claim at a time.

SECTION 10

What The Joint Operating Committee Needs To See

The joint operating committee cannot spend most of its time arguing about individual claims. It needs to look at the pattern, the dollars, the owner, and the fix. Gabeo gives the committee an operating view that leaders can act on.

Claims by expected financial responsibility compared with actual paid party.

Dollar exposure by service category, provider, facility, plan, IPA, and effective date.

Capitation deductions that do not match the expected DOFR rule.

Carve out leakage by category and contract amendment.

Authorization ownership mismatches where the financial owner and operational owner do not align.

Provider file mismatches by tax identification number, specialty, place of service, network status, and facility affiliation.

Aging of open configuration defects and the responsible owner for each issue.

Provider abrasion risk, including repeated payment disputes or providers with high unresolved exposure.

Patient access risk when provider payment or authorization confusion affects specialist availability or timeliness.

Closed loop status showing what was fixed, when it was fixed, who approved the fix, and how future claims will be monitored.

SECTION 11

What Good Looks Like After The Fix

The value of configuration integrity is not only finding old errors. The larger value is changing how delegated care is managed going forward. When Gabeo is working correctly, the plan, IPA, MSO, and provider relations team have a shared view of the operating truth.

The contract rule is visible and tied to the system rule.

The system rule is tied to claim line examples.

Claim line examples are tied to dollar exposure.

Dollar exposure is tied to owner, fix date, and monitoring status.

Capitation deductions and surplus reports are tied to validated financial responsibility.

Provider disputes are tied to root cause, not just one claim resolution.

Future amendments are tested before go-live.

Joint operating committees spend less time debating facts and more time fixing performance.

That is the standard Gabeo helps create. Delegated care cannot depend on tribal knowledge, late reconciliation, or the hope that the system was configured correctly. It has to depend on validated rules, auditable claims, and shared accountability.

Call To Action

The configuration integrity problem is solvable. It does not require the industry to accept invisible leakage, recurring disputes, provider abrasion, and unreliable delegated reporting as the normal cost of doing business.

Health plans need to know that delegated risk is being executed the way the contract intended. IPAs and medical groups need to know that capitation, deductions, settlements, and provider payments reflect the deal they actually signed. MSOs need tools that let them manage the operating model with evidence, not guesswork. Providers need faster answers and cleaner payment. Patients need networks that remain stable because the financial machinery underneath the care model is working.

Gabeo.ai is the configuration integrity layer for delegated care. The value is not only revenue recovery. The larger value is making the plan, IPA, MSO, and provider network operate from the same truth. That is what makes delegated care scalable. That is what makes capitation manageable. That is what makes risk partnerships credible.

The next step is a focused validation with one delegated arrangement, one claims history, one DOFR, one set of configuration extracts, and one shared operating report. If Gabeo can show what the contract says, what the system did, where the dollars moved, who owns the fix, and how future claims will be prevented from repeating the same error, the operating value becomes clear.

When the contract, the configuration, the claim, the capitation deduction, and the report all match, delegated care becomes much more manageable. That is the standard the industry needs. That is the standard Gabeo can help prove.

About the Authors

Michael Riley is Co-Founder and Chief Product Officer of Gabeo.ai. He brings 20+ years of enterprise software experience building technology platforms that solve complex operational problems. At Gabeo, he leads product strategy for the ARIA configuration integrity engine, working directly with health plans, IPAs, and MSOs to translate delegated care complexity into practical AI solutions.

Michael Skolnik is a healthcare executive and educator with deep experience in managed care operations, capitated delegated care, and health plan administration. He has held C-level positions in healthcare organizations and currently teaches at the graduate college level, bringing both operational and academic rigor to the configuration integrity challenge.

Octavio Campos is Director of Operations at Guidant Health, where he oversees claims operations and delegated risk management. With over a decade of experience configuring and managing DOFRs across multiple health plan relationships, he brings practitioner-level expertise in the operational realities of delegated care configuration.

Michelle Glatt is a healthcare operations executive with experience spanning both the health plan and provider sides of delegated care. Her perspective on configuration integrity bridges the gap between plan-level oversight and the operational reality of claims processing, provider relations, and benefit administration.

References

1. CMS. 2026 Medicare Accountable Care Organization Initiatives Participation Highlights. February 2026.
2. KFF. Medicare Advantage Enrollment Grew by About 1 Million People, Mainly Due to Special Needs Plans. February 2026.
3. Federal Register. Medicare Program, Contract Year 2027 and Certain Contract Year 2026 Policy and Technical Changes. April 2026.
4. CMS. Contract Year 2027 Medicare Advantage and Part D Final Rule Fact Sheet. April 2026.
5. Zhu, J. M. and colleagues. Health Care Administrative Burdens, Centering Patient Experiences. Health Services Research. 2021.
6. Bai, G. and Anderson, G. F. Correlation Between Hospital Finances and Quality and Safety of Patient Care. JAMA Internal Medicine. 2019.