Litigation Trends in the Era of Health Care Reform

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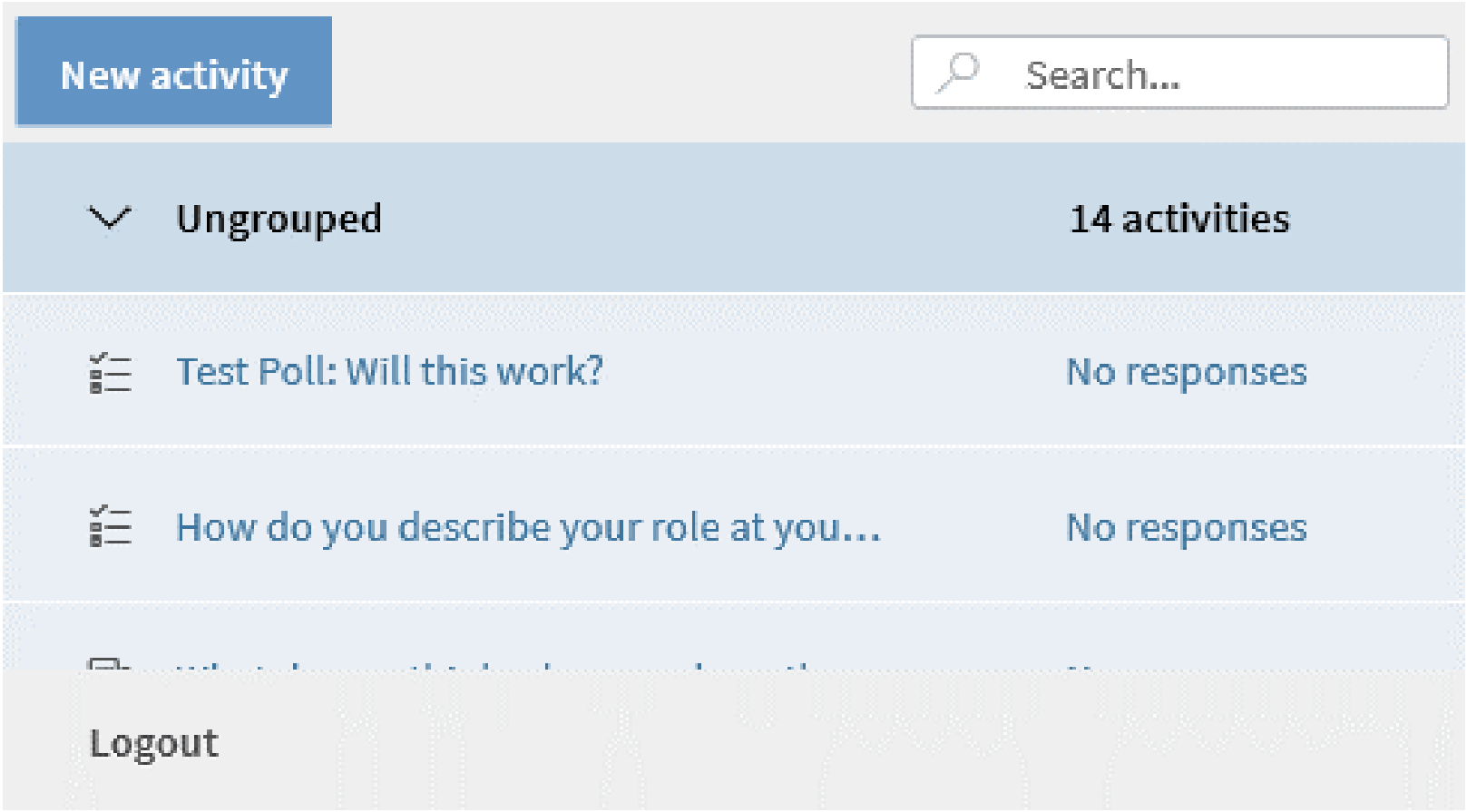
Lessons and Opportunities for Health Plans in Understanding, Avoiding, and Resolving Disputes

Poll: Who are We?
(Text AHLA19 to 22333)



Agenda

- What is Risk?
- Value-Based Reimbursement
- Integrated Financial and Delivery Systems
- Mental and Behavioral Health
- Telephone Consumer Protection Act
- Provider Directories
- Balance Billing
- Key Takeaways

Word Association: What Does Risk Mean to You?

What is Risk?

- As situation involving exposure to danger
- The uncertainty of a result, happening, or loss
- The chance of injury, damage, or loss
- Liability for injury, damage, or loss if it occurs
- Something an insurer undertakes in exchange for premium
- Something a prospective tort plaintiff knowingly assumes

What Is Risk?

Business	Insurance Law
• Strategic Risk • Compliance Risk • Operational Risk • Financial Risk • Reputational Risk	• Absorbable risk • Assigned risk • Inherent risk • Material risk • Noninsurable risk • Pure risk • Shifting risk • Speculative risk • Standard risk

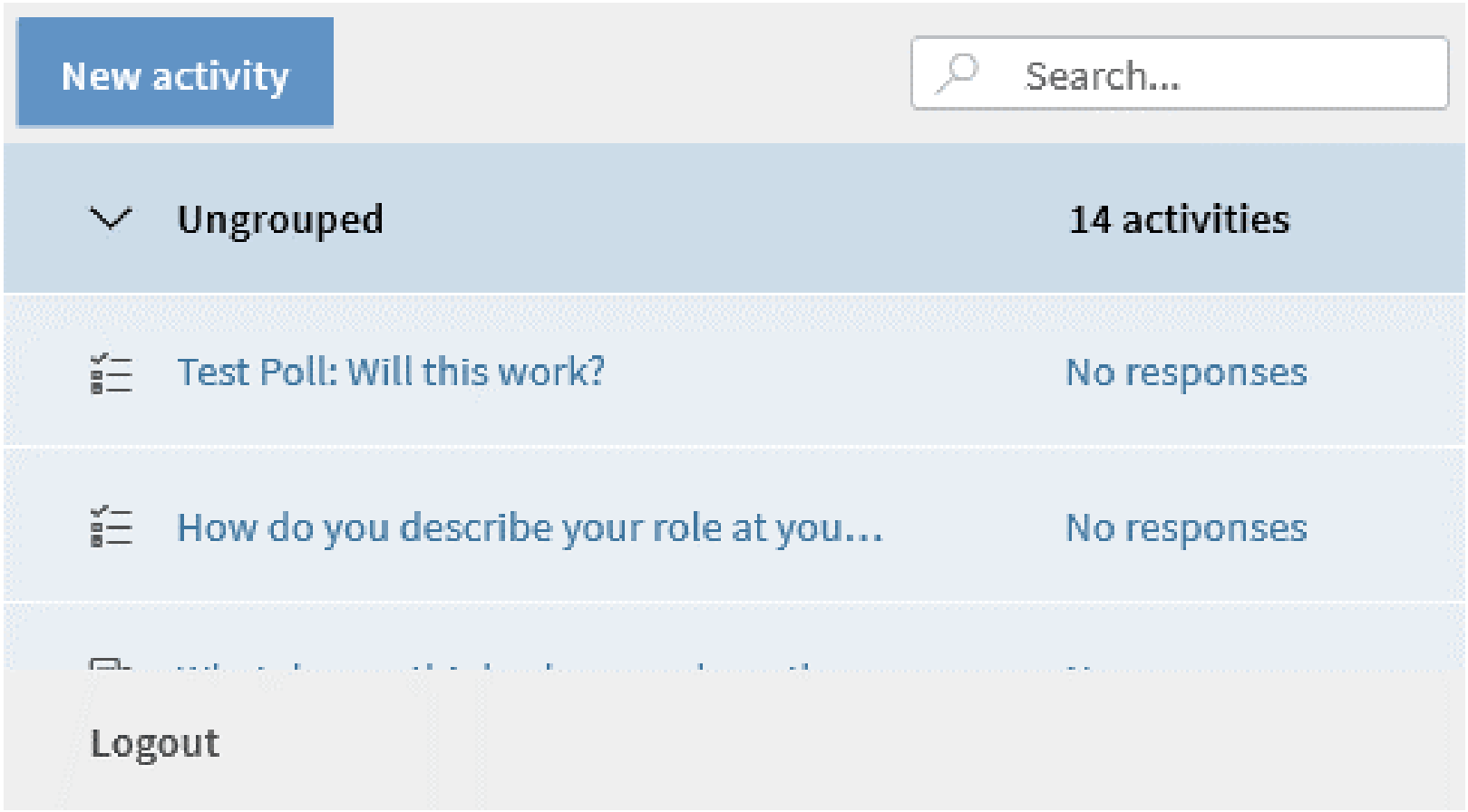
Polling Question: Insurable Risks

Top 5 Uninsurable Risks

1. Reputational risk
   - GM Recall
2. Regulatory risk
   - HIPAA, CMS, FTC
3. Trade secret risk
   - ‘How did you get the information?’
4. Political risk
   - “Buy the cover before the barn is on fire”
5. Pandemic risk
   - Swine Flu

https://riskandinsurance.com/top-five-uninsurable-risks/

Polling Question: What is Your Risk Appetite?



Top 10 Risks for 2019 in Healthcare

1. Regulatory changes and regulatory scrutiny
2. Privacy/identity management and information security
3. Existing operations meeting performance expectations, competing against “born digital firms”
4. Succession challenges and ability to attract and retain top talent
5. Cyber threats
6. Rapid speed of disruptive innovations and new technologies
7. Opportunities for organic growth
8. Inability to utilize analytics and big data
9. Resistance to change operations
10. Sustaining customer loyalty and retention

Protiviti and NCSU’s ERM Initiative, Top Risks 2019 – Healthcare Industry Group Results Summary, *available at* https://www.protiviti.com/US-en/insights/top-risks-2019-healthcare

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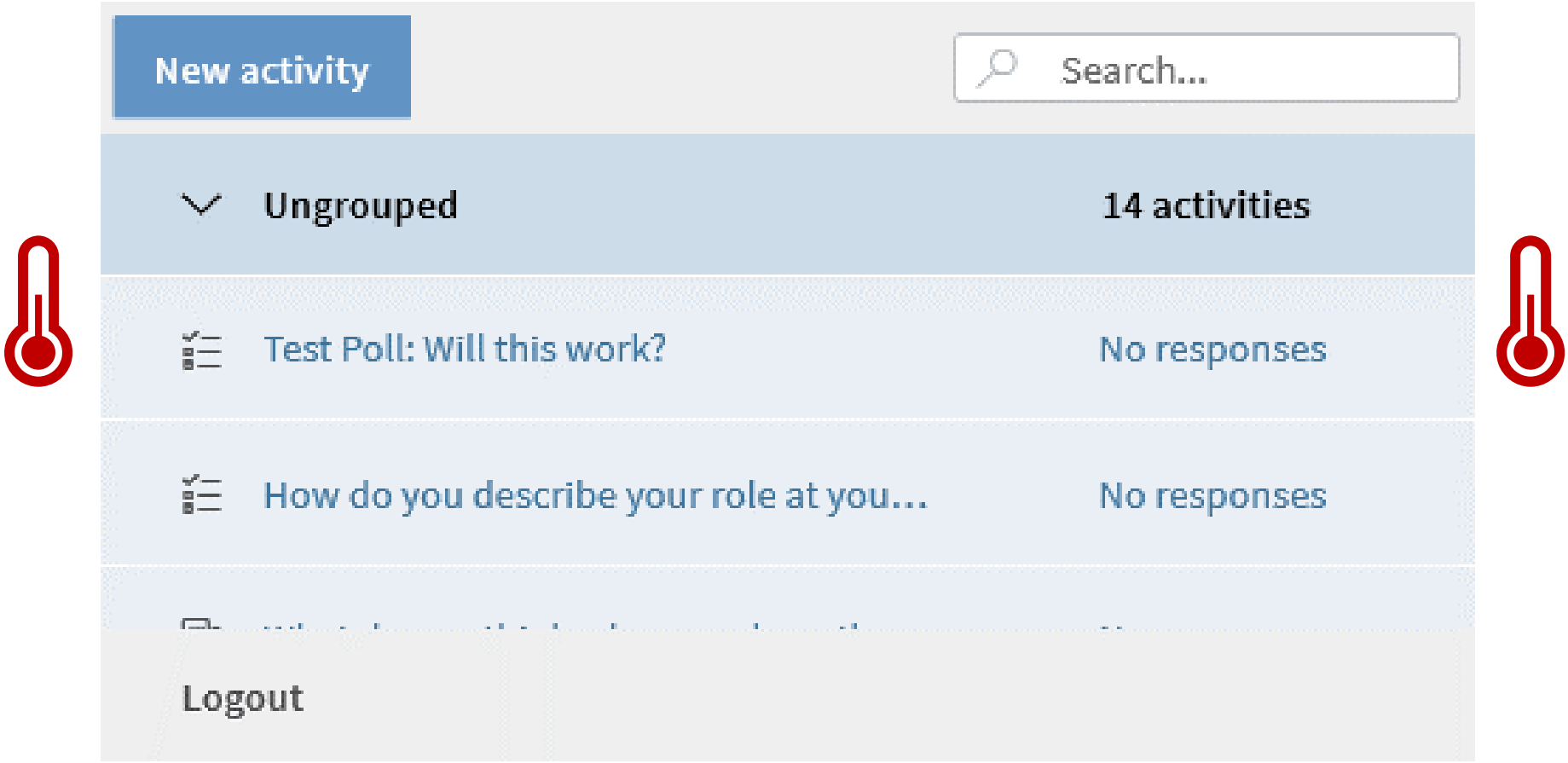
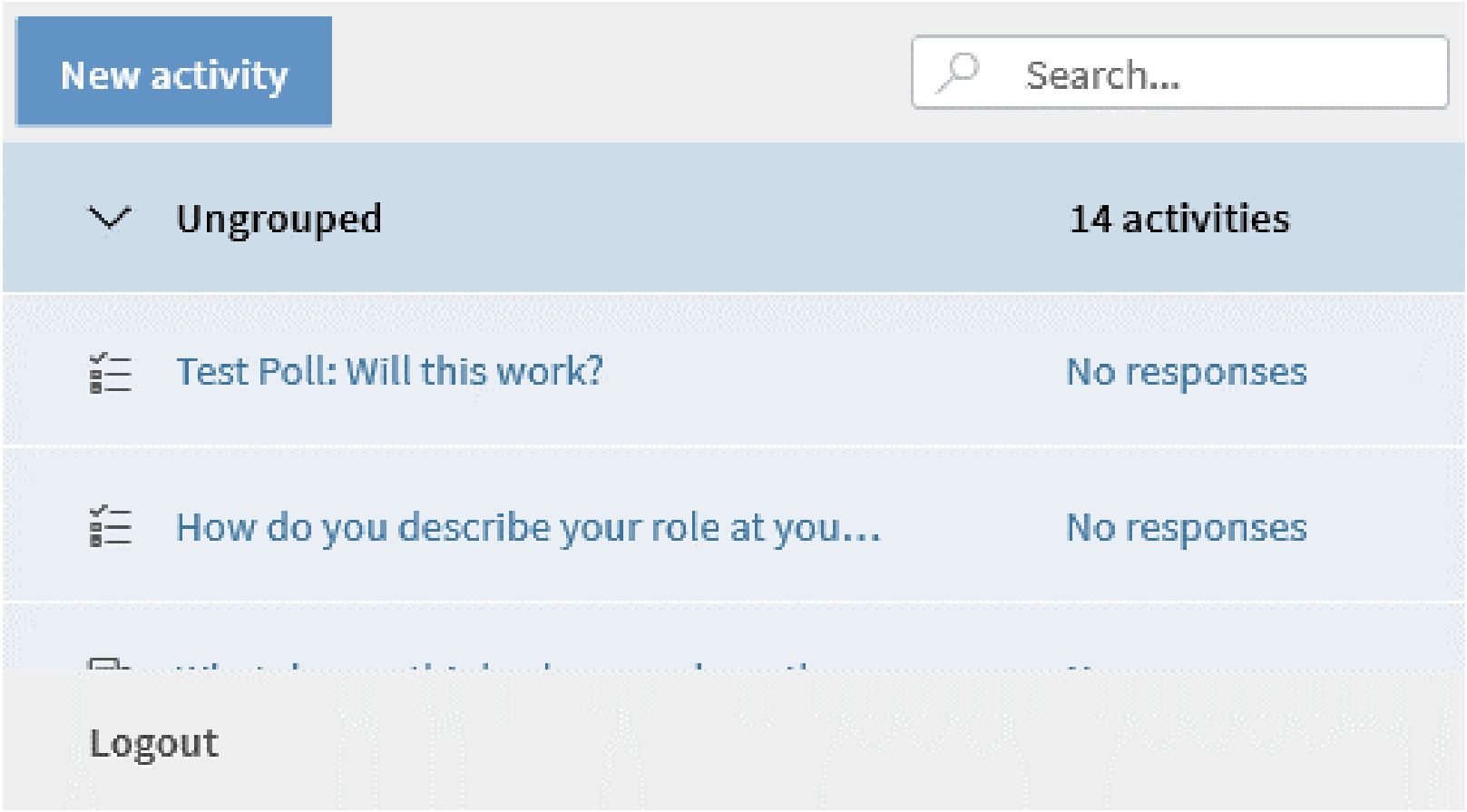
“No Margin, No Mission.”

Risk Thermometer: Where is the Risk?



Poll: What's Going On Here?



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VALUE-BASED REIMBURSEMENT

COLLABORATION

CONTRACTING

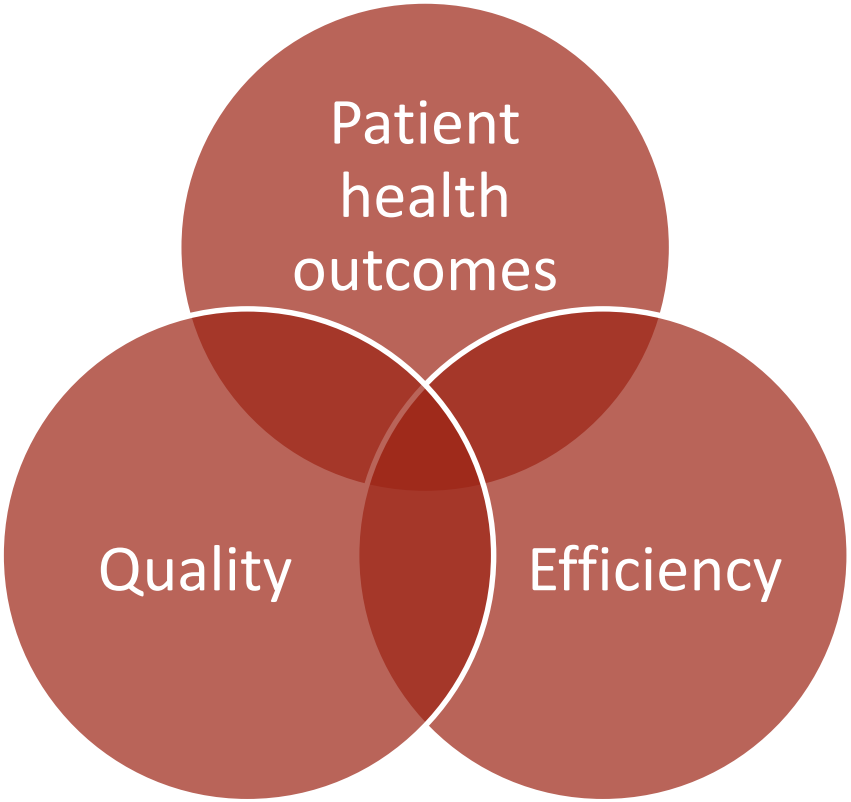
What is Value-Based Reimbursement?

Payment based on indicators of value

Distinct from volume or FFS based contracting

What is Value? What is Quality? How Do You Measure It?

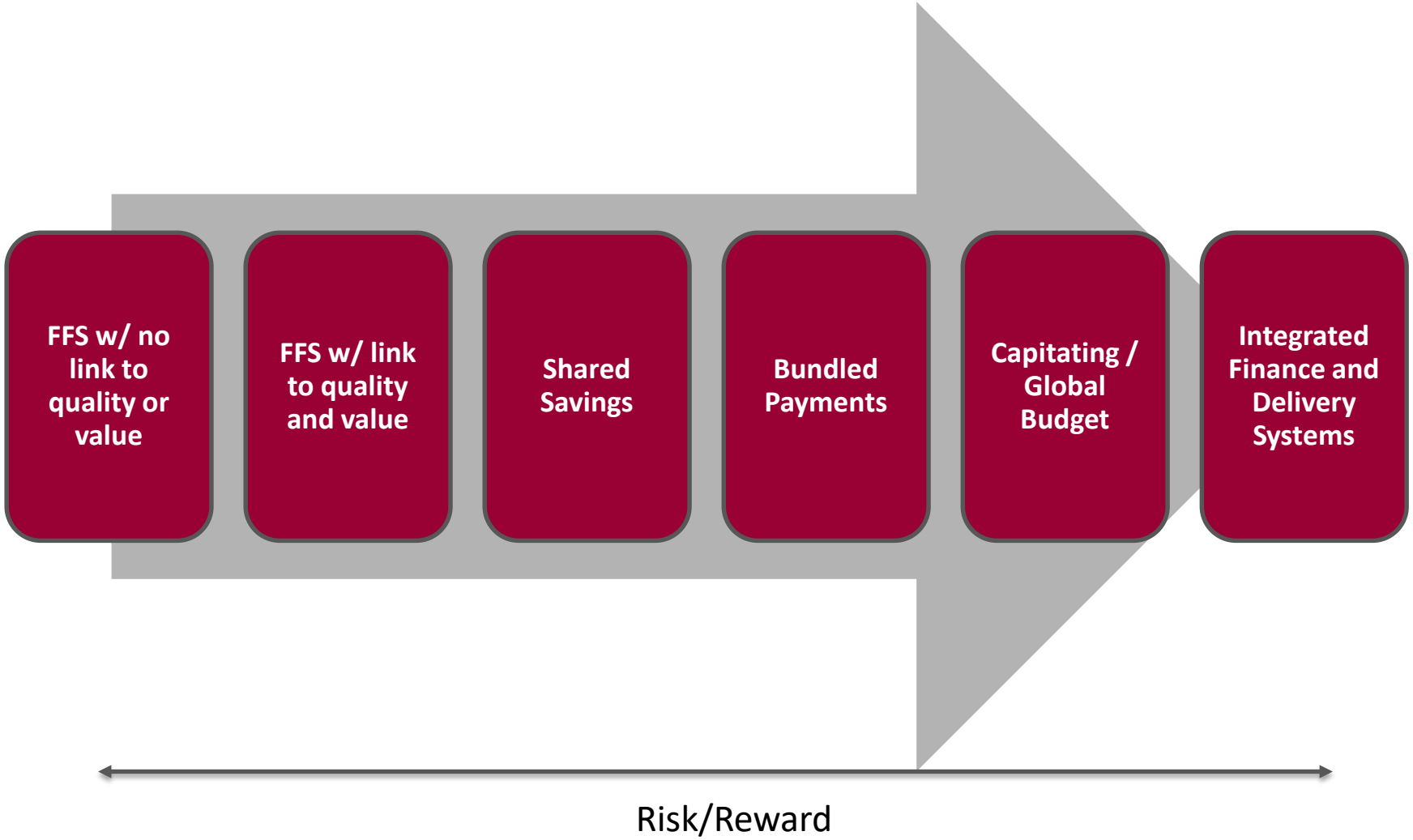
- "Value" = Quality/Cost
- Quality Measures:
  - Patient/caregiver experience
  - Patient safety
  - Preventative care
  - Patient outcomes



What is Value-Based Reimbursement?

- Incentivizes and holds providers accountable for the total cost, patient experience and quality of care for a population of patients
- Rewards health care providers with incentive payments for the quality of care they give to patients
- Aims to provide better care for individuals; better health for populations; and lower costs
- Part of a larger reform strategy
- Based on three premises: reduce costs; share savings; increase volume through market share gains

VBR: Options for Incorporating Risk



VBR: Components of a Value-Based Contract

- Measurement/performance period
- Performance/cost/utilization targets
- Arrangement type/services included
- Patient Attribution
- Payment
  - Reconciliation
  - Shared savings/losses
- Quality measures
- Financial protections
- Reporting

VBR: Model Language

- Performance Determination. For each Performance Year during the Term of this Agreement, Physician's performance will be determined based on the formula and metrics set forth in Exhibit __ attached hereto, including risk adjustment factors, and by reference incorporated herein. [The method by which Physician's performance is determined, including factors governing risk adjustment, shall only be amended upon mutual agreement of the parties by execution of a written amendment to the agreement by the parties pursuant to Section __ of the agreement.]

- Payment and Reconciliation. Payer will remit payment pursuant to the performance determination and perform any necessary reconciliation within thirty (30) days of the end of each performance period.

VBR: Model Language

- Covered services. During the Term of this Agreement, Physician shall be eligible to receive bonus payments based on the criteria set forth herein for the services and corresponding Current Procedural Terminology (CPT®) codes set forth on Exhibit ____ attached hereto and by reference incorporated herein for services he or she personally performed and those that were performed "incident to" Physician ("Covered Services"), and which may be amended, from time to time, by mutual, written agreement of both parties, pursuant to Section ____. Those Covered Services set forth in Exhibit ____ which are designated as part of an "episode" of treatment shall not be separately billed by the physician and/or "incident to" provider during the episode period when treating a covered person.

Model Language for Accountable Care Organizations

- **Cost Measurement and Savings Determination.** ACO shall reduce overall spending and moderate trend to target CPI or less. For purposes of assessing cost savings, the Company will apply a prospective patient attribution model. Subject to mutual agreement, the parties may identify a designated patient population based on a specific geographic catchment area, claims incurred prior to the period of the attribution analysis, or open enrollment benefit plan selection. The ACO will have a defined patient population for purposes of cost and quality measurement, as well as to target care coordination strategies. Such attribution or designation will be updated quarterly.

- If the ACO is contracted with the Administrator under a fee-for-service payment model, the ACO shall implement a shared-risk payment arrangement designed to align provider incentives and reduce overall costs that includes the following characteristics:
  - An aggregate minimum savings rate of X% must be achieved before any savings are distributed.
  - Company and ACO shall agree upon a clearly defined measure of the ACO's cost savings prior to the start of this contract. The ACO will be able to share up to 50% of the savings above the minimum saving rate, if it meets 100% of the quality standards described in Appendix A. Savings shall be capped at not more than 15%* of the medical cost target for that given year. ACO or Administrator may elect to apply a withhold on fee-for-service payments to fund the shared savings arrangement.
  - If the ACO does not reach cost targets outlined in Paragraph 2a above, the ACO will be responsible for up to 50% of losses on a schedule to be mutually agreed upon.
  - Medical cost will be case-mix adjusted.
  - Geographically out-of-area claims will be excluded provided ACO has made best efforts to repatriate the Participant in its provider network as clinically appropriate.

Source: Catalyst for Payment Reform and Pacific Business Group on Health

Model Language for Accountable Care Organizations

- If the ACO is contracted with the Administrator under a capitation and/or existing shared-risk payment arrangement, benchmarks shall be created each performance year based on both historical claims data and prospective trending.
  - A minimum savings rate of X% must be achieved before any savings are distributed.
  - Company and ACO shall agree upon a clearly defined measure of the ACO's cost savings prior to the start of this contract. The ACO will be able to share up to 50%* of the savings above the minimum saving rate, if it meets 100% of the quality standards described in Appendix A. Savings shall be capped at not more than 15%* of the benchmark of that given year.
  - If the ACO does not reach cost targets outlined in Paragraph 3a above, the ACO will be responsible for 50%* of losses. Losses will be capped with a sliding rate, starting at a minimum of 5% percent of the ACO's medical cost benchmark in year one, ramping up to 10% by year three.*
  - Medical cost will be case-mix adjusted.
  - Geographically out-of-area claims will be excluded provided the ACO has made best efforts to repatriate the Participant in its provider network as clinically appropriate.

- Company and ACO agree to a timely reconciliation period. Cost savings will be measured after the initial year of operation, based on a 90-day claims lag. The claims reporting and analysis period will be completed by 180 days after the close of the operating year.

Source: Catalyst for Payment Reform and Pacific Business Group on Health

Model Language for Accountable Care Organizations

APPENDIX A: QUALITY, PATIENT EXPERIENCE, COST AND UTILIZATION MEASURES

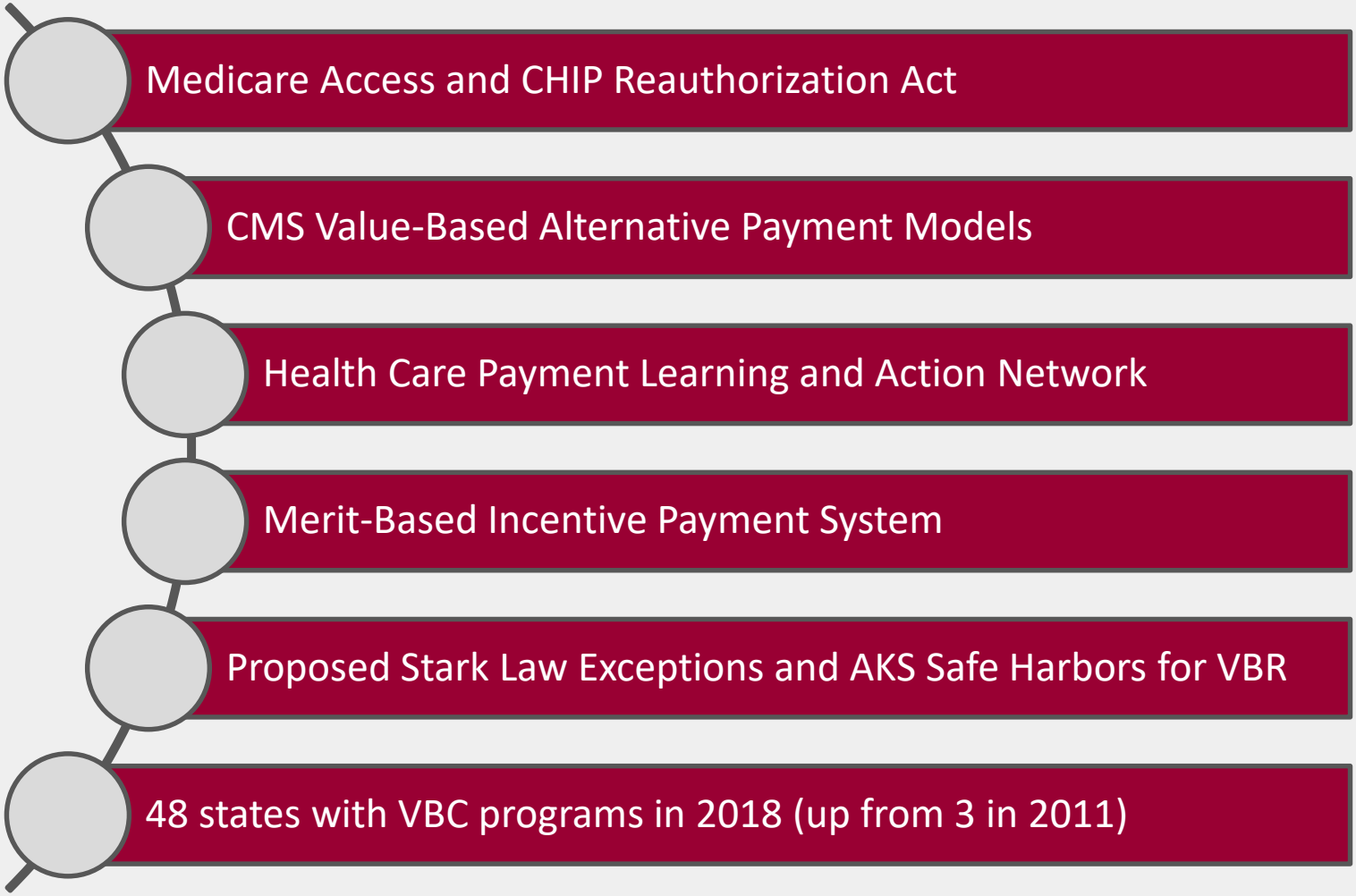
Company and ACO [or Administrator] will mutually agree upon a benchmark for comparing results such as NCQA national performance percentiles, or publicly reported statewide plan or provider organization performance percentiles. Targets will reflect an improvement relative to prior year experience based on the following schedule:

If current performance is at:	Target improvement
90th percentile	Maintenance
75th percentile	2%
50th percentile	4%
25th percentile or less	10%

Domain	Measure Name	Description	Endorsement	Target	Frequency*
Quality					
At Risk Population – Diabetes					
	HbA1c control	Percentage of patients with HbA1C levels in control (8 and >9)	NQF #729		Quarterly
	Blood pressure control	Percentage of patients with blood pressure <140/90	NQF #729		Quarterly
	Lipid control	Percentage of patients with LDL-C<100 mg/DL	NQF #729		Quarterly
Optional	Optimal Diabetes Care - Process - Outcomes	*To the extent that there are data gaps in clinical outcomes measures, the parties may elect to use the composite measure that captures the percentage of diabetes patients who meet ALL individual process (testing) measures. If performance in the three measures listed above is satisfactory, the parties may elect to use the composite outcomes measure that includes these measures, non-smoking status and daily aspirin use.*			

Source: Catalyst for Payment Reform and Pacific Business Group on Health

VBR: Legal and Regulatory Landscape



VBR: Current Snapshot

Payments increasingly tied to value

- 36% of total U.S. healthcare payments in 2018 went to APMs that required some type of financial accountability from providers – up from 34% in 2017 and 25% in 2015
- 47% of HTTF member payer/provider business tied to VBR in 2017
- Private payers overtook gov't implementing VBR in 2018

Payers report benefits from VBR

- Report reduced unnecessary medical costs
- Improvements in care quality
- Provider relationship improvements
- Improved patient engagement

Payers optimistic about VBR

- 97% of respondents believe APMs will lead to better quality
- 88% believe they will cause more affordable care

VBR: Current Snapshot

Challenges may slow growth

- Implementing new programs takes time
- Little agreement about the best value-based model
- Low expectation that VBR programs will grow over the next two years

Biggest challenges

- Changing regulations/policies
- Trouble collecting and reporting patient data
- Complexity of financial risk and unpredictability of revenue stream
- Lack of resources
- Interoperability gaps

VBR: Provider Awareness versus Engagement

VBR: Relationship Success Drivers

Provider Indicators	Health Plan Levers
• Awareness • Interest • Advocacy • Satisfaction	• Program design • Communication • Support

VBR: Support Gap

Overdelivered	Underdelivered	No gap
• Peer comparisons • Population health data • Performance Reports	• Consultative support • Clinical support • Stop-Loss insurance • Admin support	• Cost data and reporting tools • Identifying high risk patients

VBR in the Courts

- Capital Health Sys., Inc. v. Horizon Healthcare Services, Inc., No. C-369-15 (N.J. Super. Ct. Mar. 5, 2018)
  - Did Horizon breach contract obligations to in-network hospitals by creating tired network insurance plan based in part on potential to transition to VBC

Best Practices for Transitioning to VBR

- Financial flexibility
- Gradually introduce increasing levels of risk
- Regularly assess provider engagement/readiness
- Invite provider input and feedback
- Tailor measures to providers' performance goals
- Invest in care management
- Invest in data analytics
- Provide information/incentives at individual level
- Take the long view

VBR: Risk Mitigation

Provider contracting

- Transparency – no black boxes
- Network changes and credentialing criteria
- Payment mechanisms
- Deliverables and data
- Dispute resolution
- Flexibility to reassess

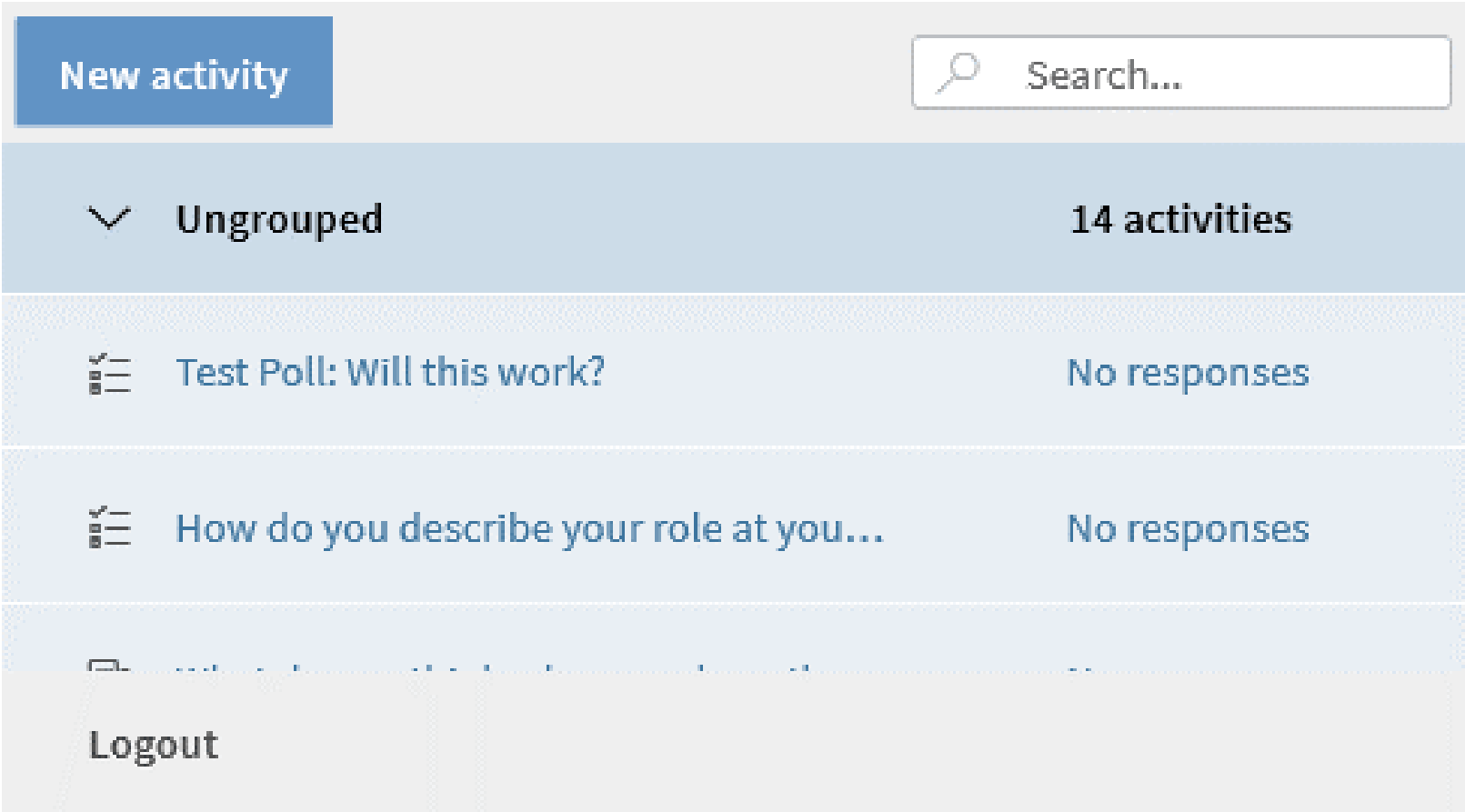
Claims handling

- Update payment-automation processes for new models

VBR: Key Takeaways

- Maintain financial flexibility
- Develop sufficient data
- Manage risk of unforeseen variables
- Nurture provider relationships
- Anticipate challenges to identify opportunities

VBR: Risk Thermometer



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INTEGRATED FINANCIAL AND DELIVERY SYSTEMS

COORDINATION

CULTURE

COST SAVINGS

Provider-Sponsored Health Plans

Provider-Sponsored Health Plans (PSHP): a health plan that is financially supported by a healthcare provider

- Natural outgrowth of transition to VBR and integrated delivery systems
- Response to consolidation of national payers

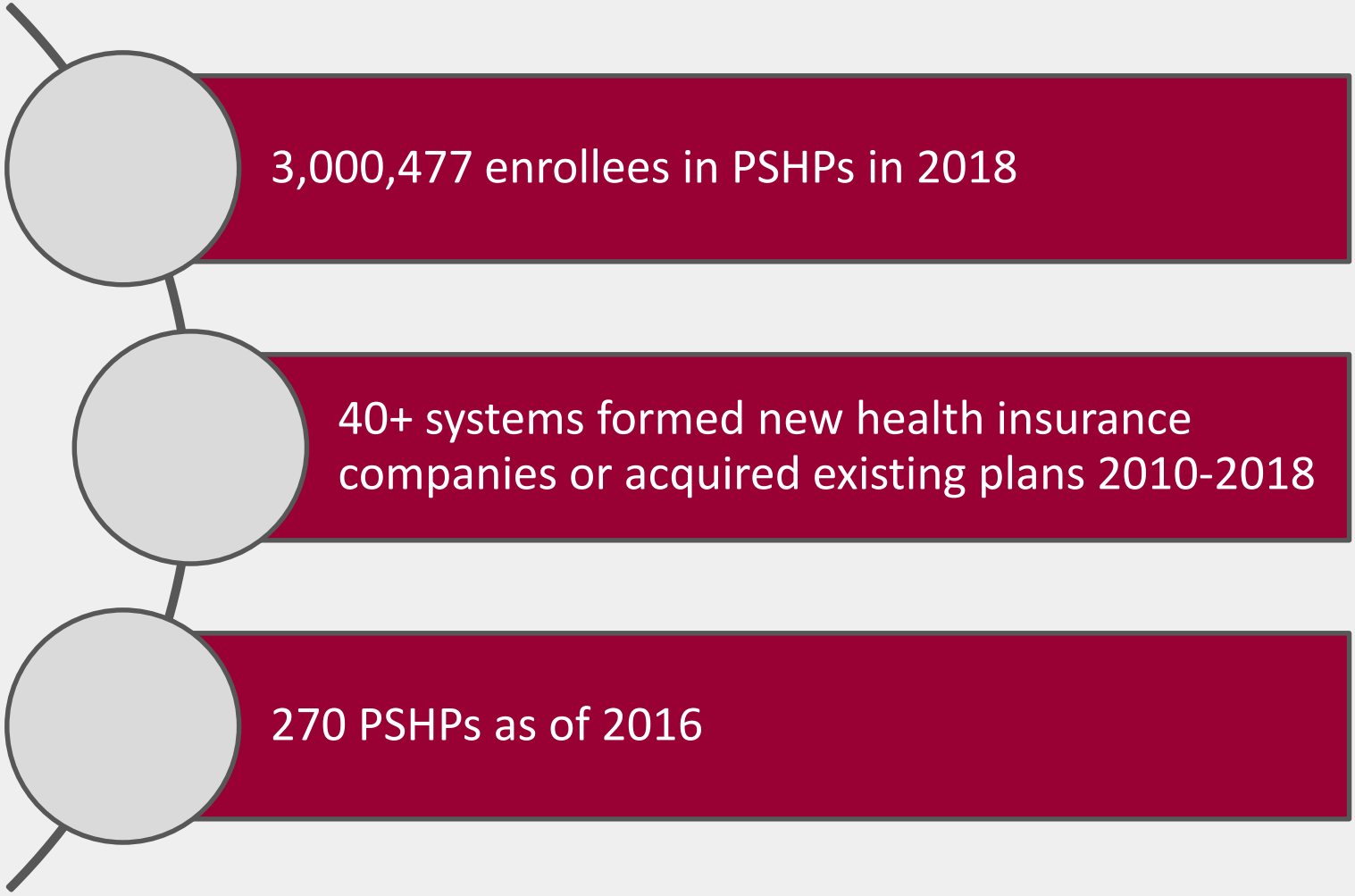
PSHP Models

- Payer and provider develop a co-branded product
- Provider creates a new plan through a subsidiary
- Provider acquires an existing plan
- Provider forms a joint venture with an established payer

PSHPs: Benefits and Limitations

Benefits	Challenges
• Population health • Member satisfaction • Financial performance	• Model does best in populous urban areas • Multiple levels of transition • Conflict between plan and system

PSHPs: Current Snapshot



PSHPs: Litigation Risk

Stark Law

- Prohibits physicians from making Medicare referrals for designated health services to healthcare entities with which they have a financial relationship
- Should not apply to PSHPs because PSHPs do not make or receive patient referrals and are not Designated Health Services entities
- Potential liability based on indirect compensation theory if:
  - The compensation arrangement between physician and PSHP is based on volume or value of referral business and
  - The hospital owner has actual knowledge or acts in reckless disregard of compensation arrangement
- Current exceptions for risk-sharing arrangements and PIPs
- Proposed new exceptions for value-based arrangements

PSHPs: Litigation Risk

Anti-Kickback Statute

- Makes it illegal to knowingly and willfully offer, pay, solicit, or receive remuneration (directly or indirectly) in exchange for patient referrals or for arranging for an item/service payable under a federal healthcare program
- Potential liability for compensation methodology funded by healthcare parent and distributed by PSHP
- Proposed new safe harbors for value-based arrangements

Proposed Exceptions and Safe-Harbors for Value-Based Arrangements

- Value-based Enterprise (VBE) = two or more VBE participants collaborating to achieve at least one value-based purpose
  - Collaboration by two individual physicians
  - Network of hospital systems, providers, and physician practices

- Value-based Purpose =
  - Coordinating and managing the care of a target patient population;
  - Improving the quality of care for a target patient population;
  - Appropriately reducing the costs to, or growth in expenditures of, payors without reducing the quality of care for a target patient population; or
  - Transitioning from health care delivery and payment mechanisms based on the volume of items and services provided to mechanisms based on the quality of care and control of costs of care for a target patient population

- Value-based Activities = provision of an item or service, taking of an action, or refraining from taking an action
  - Provided the activity is designed to achieve at least one value-based purpose
  - Does not include making referrals

- Value-based Arrangement = an arrangement for the provision of at least one value-based activity for a target patient population

Proposed Exceptions and Safe-Harbors for Value-Based Arrangements

CMS

- Full financial risk (to the VBE)
- Meaningful downside financial risk (to the physician)
- Value-based arrangements
- Indirect value-based arrangements

OIG

- Full financial risk (to the VBE)
- Substantial downside financial risk (to the VBE)
- Care coordination arrangements to improve quality, health outcomes, and efficiency
- Patient engagement and support

PSHPs: Litigation Risk

Anti-Trust

Potential increased scrutiny

- Regulators focused on horizontal integration
- Vertically consolidated hospitals increased 21% from 2007-2012
- 115 hospital/health system transactions in 2018
- FTC studying impact of COPAs

Anticompetitive concerns

- Barriers to entry for new payers/providers
- Integrated systems unwilling to contract with competitors
- Lack of incentive to lower premiums

Competitive benefits

- Generated cost-savings
- Increased competition within integrated system

PSHPs: Litigation Risk

Contracting Disputes

UPMC/Highmark Health in Pittsburgh

- Eight-year contract dispute in multiple forums between rival integrated systems
- Resolved June 24, 2019 with 10-year agreement to let Highmark patients continue receiving care at UPMC facilities in Western PA

PSHPs: Takeaways

Risk Mitigation

- Multi-year transition plan
- Focus on shifting the culture
- Avoid volume-based compensation arrangements
- Document cost-savings and quality improvement purposes of compensation arrangements
- Proposed value-based regulations

Best Practices/Success Stories

- Integrated Structure
- Prepayment
- Advanced IT systems
- Culture of physician leadership

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MENTAL AND BEHAVIORAL HEALTH

Putting Parity in Context

Mental/Behavioral Health: Legal and Regulatory Landscape

Mental/Behavioral Health: Legal and Regulatory Landscape

Summary of MHPAEA Protections

- "Substantially all/predominant test" – financial requirements and treatment limitations for MH/SUD no more restrictive than those that apply to substantially all medical/surgical benefits
- No separate cost-sharing requirements or treatment limitations for MH/SUD
- If OON medical/surgical benefits provided, must also provide for OON MH/SUD
- Medical necessity determination standards and denial reasons disclosed upon request

Mental/Behavioral Health: Legal and Regulatory Landscape

Exceptions to MHPAEA requirements

- Self-insured non-federal governmental plans with ≤ 50 employees
- Self-insured small private employers with ≤ 50 employees
- Group health plans and health insurance issuers exempt based on increased cost
- Large, self-funded non-federal governmental employers that opt-out of MHPAEA requirements

Mental/Behavioral Health: Current Snapshot

- Private insurance claims for behavioral health diagnoses up 320% from 2007-2017
- Private health companies pay 13-14% less for mental health care than Medicare
- OOP spending on inpatient mental health care grew 13x faster than all inpatient care
- Therapist office visit 5x as likely to be OON than a primary care appointment
- Litigation on the rise

Mental/Behavioral Health in the Courts: Coverage Cases

Claims Dismissed

- **Robert O. v. Harvard Pilgrim and UBH (D. Utah July 25, 2019)**
  - SJ for Harvard Pilgrim and UBH
  - Plaintiffs failed to obtain preauthorization
  - Treatment not medically necessary
- **Kerry W. v. Anthem (D. Utah June 5, 2019)**
  - MTD granted
  - Denial of MH benefit claim based on medical necessity cannot be transformed into MHPAEA claim through conclusory allegations

Claims Proceed to Discovery

- **ex rel. Juno Therapeutics, Inc. v. Blueshield, 33 F. Supp. 3d 1069 (W.D. Wa. 2018)**
  - MTD denied
  - Allegation that entity generally covers M/S services in intermediate settings and practice of excluding wilderness therapy sufficient
  - Plaintiff entitled to test Defendants' processes for denying coverage
- **David S. v. United Healthcare Ins. Co. (D. Utah Sept. 13, 2019)**
  - MTD denied
  - Plausible that United's acute nonquantitative treatment limitations are more stringent than its sub-acute nonquantitative treatment limitations

Mental/Behavioral Health in the Courts: Coverage Cases

- **Wit v. United Behavioral Health (N.D. Cal. Mar. 5, 2019)**
  - Core claims:
    - Breach of fiduciary duty under ERISA
    - Denial of benefits under ERISA
  - Mar. 30, 2019 Order:
    - UBH plan fiduciary with respect to Plaintiffs' plans by virtue of its designation as administrator of MH/SUD benefits under their Plans
    - UBH breached its fiduciary duty under an abuse of discretion standard by adopting Guidelines that are unreasonable and were more restrictive than generally accepted standards of care

- **Meridian Treatment Services, et al. v. United Behavioral Health (N.D. Cal.)**
  - Complaint filed September 11, 2019
  - Based on Wit decision finding that coverage guidelines UBH has followed since 2011 were fundamentally faulty

Mental/Behavioral Health in the Courts: Funding Litigation

- **Serenity v. BCBSMI (1:19-cv-00620) (W.D.M.I.)**
  - Complaint filed July 31, 2019
  - Substance abuse treatment facilities allege that BCBSMI cut reimbursement rates in 2016 leading, causing private providers to turn away patients and stick patients with surprise medical bills.
  - Alleges reimbursement rates for residential inpatient care dropped from $1,313/day to $151 from April-July 2016
  - Also alleges claims processing and payment issues were systematic attempts to avoid coverage for out-of-network claims (e.g., requiring claims to be submitted by mail).

Mental/Behavioral Health: Challenges for Health Plans

Differences in treatment infrastructure

- Demand exceeds supply
- Lack of evidence and standards for assessing quality
- Federal regulations limiting access to SUD information
- Disclosure requirements

Patient Brokering Epidemic

- When a substandard treatment center pays a recruiter to bring in commercially insured patients
- Accelerated by the opioid epidemic

Mental/Behavioral Health: Takeaways

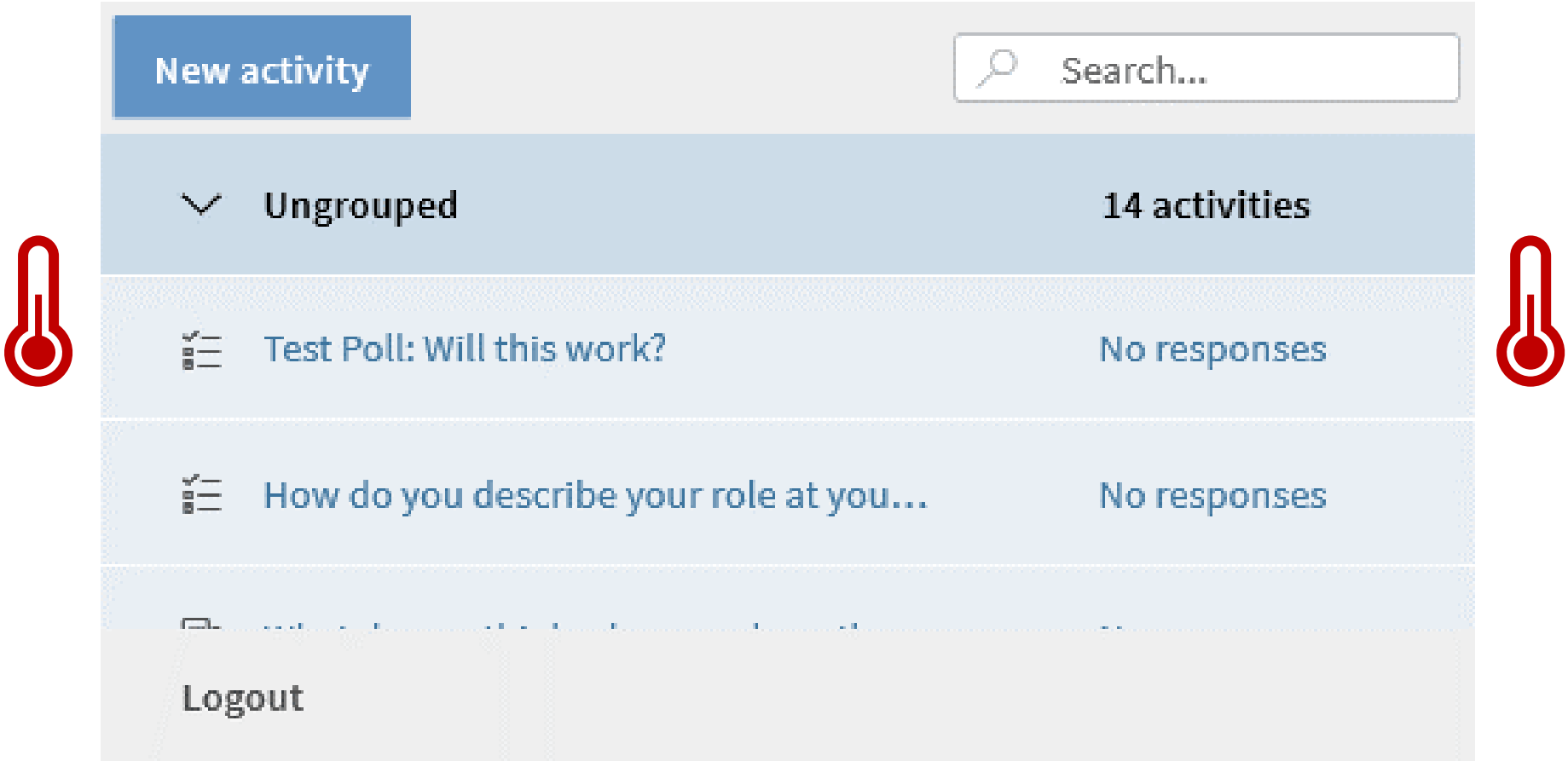
Risk Mitigation

- Regularly evaluate policies and operations in light of parity requirements
- Internal coverage guidelines
- Claims-handling standards and procedures
- Education (plan, provider, patient, decisionmaker)

Best Practices/Success Stories

- Integrate behavioral and medical health services
- Build strong provider networks
- Partnerships to offer behavioral health benefit packages
- Member education and provider outreach
- Identification of members with behavioral healthcare needs

MBH: Risk Thermometer



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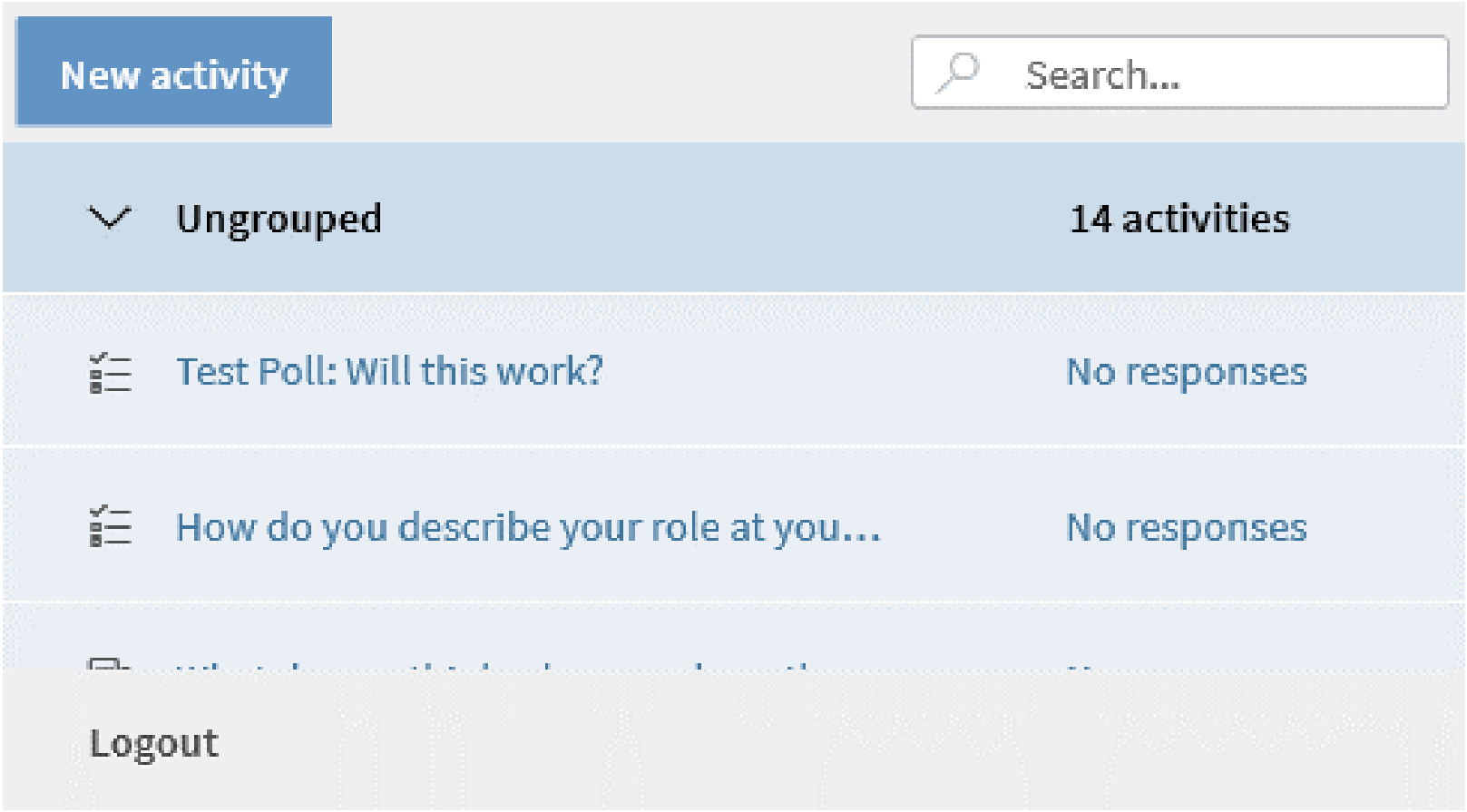
TELEPHONE CONSUMER PROTECTION ACT

COMPLIANCE

CONSENT

CONTENT

Poll: How many of us are using automated calling and texting to communicate with members?



TCPA: Legal and Regulatory Landscape
Telephone Consumer Protection Act of 1991

- Enacted to protect consumers from unsolicited telemarketing communications)
- Restricts telephone solicitations and the use of automated telephone equipment.
- Limits the use of automatic dialing systems, artificial or prerecorded voice messages, SMS text messages, and fax machines without obtaining the recipient's prior consent
- Specifies technical requirements for fax machines, autodialers, and voice messaging systems
- Applies to both sales and non-sales calls
- Empowers FCC to interpret TCP through rules, regs, and declaratory rulings

TCPA: Legal and Regulatory Landscape

- 2012 FCC Order
  - Healthcare calls covered by HIPAA exempt from TCPA liability
- 2015 FCC Order
  - Expands liability under TCPA
  - Recognizes limited healthcare treatment purpose exemption
- *ACA Int'l v. FCC*, 885 F.3d 676 (D.C. Cir. 2018)
  - Upheld restrictive healthcare treatment purpose exemption

TCPA: Legal and Regulatory Landscape

Healthcare Exemptions

- Calls to residential landlines that deliver a **healthcare message** from a HIPAA-covered entity or its business associate are completely exempt and can be made without consent
- **The Healthcare Rule** – Calls and texts to cell phones using an autodialer or an artificial or prerecorded message that deliver a **healthcare message** from a HIPAA-covered entity or its business associate require prior express consent
- Limited exemption for calls/texts regarding **vital, time-sensitive calls with a health-treatment purpose**; communications must meet seven strict conditions

What is a healthcare message?

A healthcare message meets three criteria:		
The call concerns a product or service that is inarguably healthcare related	The call is made to a patient with whom the healthcare provider has an established healthcare relationship	The call concerns the individual healthcare needs of the patient relationship

TCPA: What is an ATDS?

- TCPA defines ATDS as equipment with "capacity" to:
  - "store or produce telephone numbers to be called, using a random or sequential number generator," and
  - "dial such numbers."
- 2015 FCC Order defined ATDS as equipment with
  - potential to dial random or sequential numbers
  - Even if not presently used for that purpose
- Mar. 2018 – D.C. Cir. rejected broad FCC definition
- Oct. 2018 – FCC received comments on ATDS definition
- 2019 Courts remain split over definition of ATDS and impact of 2015 FCC Order

TCPA: Other Issues

- Reassigned Numbers
  - Calls made with the prior express consent of the "called party" do not violate the TCPA
  - Actual recipient or intended recipient?
  - Reassigned number database and safe harbor
- Revocation of Consent
  - Consumers may revoke consent at any time through any reasonable method that, based on "the totality of the facts and circumstances," expresses "a desire not to receive further messages."

TCPA: Litigation Risk

High risk of private litigation

- TCPA creates private right of action
- Strict liability
- Statutory damages of $500 per violation
- Treble damages if violation is willful or knowing)
- No cap
- Potential injunctive relief
- Fertile ground for class actions

TCPA class action settlements in the healthcare industry

- Kaiser Permanente – $5.4M
- CynoSure – $16M
- PharMerica – $15M
- Anthem – $6.25M
- Walgreens – $11M

TCPA: What the Courts Say

- ***Latner v. Mount Sinai Health Sys.*, No. 17-99-cv (2d Cir. 2018)**
  - Single text message to a patient reminding him to get a flu shot protected from TCPA liability because plaintiff consented to be contacted for treatment
- ***Zani v. Rite Aid Headquarters Corp.*, 246 F. Supp. 3d 835 (S.D.N.Y. 2018), *aff'd*, 725 Fed. Appx 41 (2d Cir. 2018)**
  - Affirmed SJ in favor of Rite Aid over prerecorded flu shot reminder calls
- ***Bailey v. CVS Pharmacy, Inc.*, 2018 WL 3866701 (D.N.J. Aug. 14, 2018)**
  - Text messages notifying customers that their prescription was ready to be picked up with the phrase "flu shots available" qualified for healthcare exemption
- ***Smith v. Rite Aid Corporation*, 2018 WL 5828693 (W.D.N.Y. Nov. 17, 2018)**
  - Pharmacy prescription reminder calls are not categorically protected by the emergency purposes exception
- ***Coleman v. Rite Aid of Georgia, Inc.*, 284 F. Supp. 3d 1343, 1344 (N.D. Ga. 2018)**
  - Pre-recorded automated voice message from Rite Aid regarding prescription message not subject to healthcare exemption because recipient provided no consent
- ***Sullivan v. All Web Leads, Inc.*, No. 17-cv-1307, 2017 WL 2378079 (N.D. Ill. June 1, 2017)**
  - Marketing call offering health insurance not a healthcare message

TCPA: Takeaways

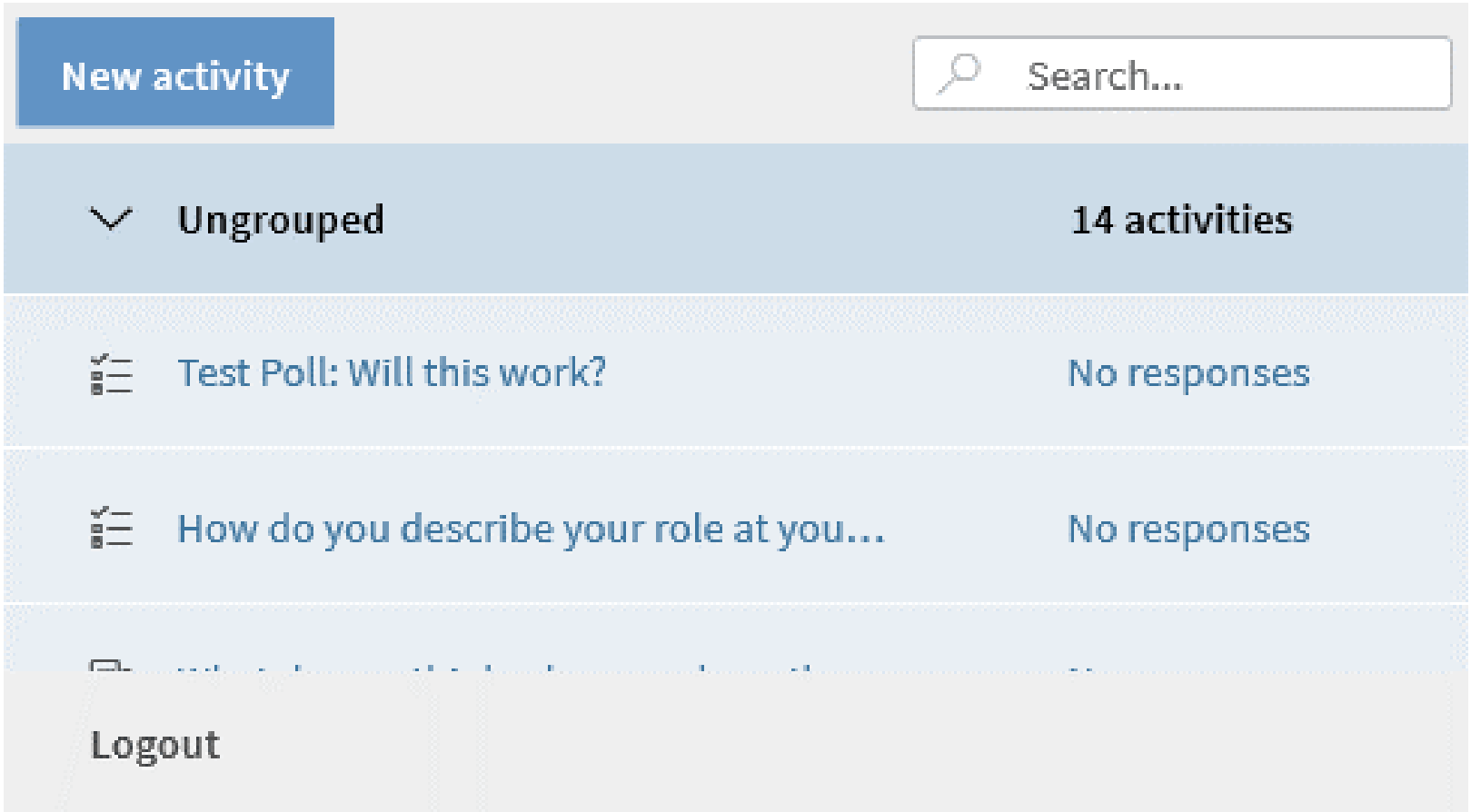
Health Plan Challenges

- Operational challenges
- Litigation risk
- Dilution of healthcare exemption
- Lack of clear direction from courts
- Inherent industry risk

Risk Mitigation

- Compliance program
- Documented consent
- Message content

TCPA: Risk Thermometer



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PROVIDER DIRECTORIES

CONSITENCY CLARITY CREATION

Provider Directories: Federal Law

Affordable Care Act QHP Standards	CMS Criteria for Medicaid MCOs	CMS Criteria for MAOs
• "Up-to-date accurate and complete" • Must be available online to public • Paper directory available on request	• Must be updated within 30 calendar days of receiving updated provider info (electronic) or at least monthly (paper)	• Must provide hard copies at time of enrollment and annually after by Oct 15 or distinct and separate notice of how to find online directory and request a hard copy

Provider Directories: State Law

Thirty states have provider directory requirements

- 22 states require online/electronic provider directories
- 9 states require paper directories
- All states require specific data elements to be included
- States have different timeframe requirements for updating provider directories
- 15 states require process to ensure accuracy
- CA and GA impose affirmative obligation on providers
- NY requires providers to notify plans of change in hospital affiliations

NAIC Health Benefit Plan Access and Adequacy Model Act

- Adopted by 4 states (CO, GA, HI, and MD)
- Requires a current and accurate provider directory for each of network plans
- Requires directories to be updated “at least monthly”
- Encourages states to consider verification requirement
- Issues arising from “material misrep” in directory referred to consumer complaint division
- Directs carriers to conduct periodic audits

Provider Directories: Current Snapshot

31% of 1,500+ healthcare consumers surveyed use their health insurance plan's website to find a doctor

New markets and new members rely on provider directories

People of all age groups, genders, income levels, and living environment believe it is important to have access to information online

Provider Directories: What's the Problem?

Researchers found that Google Places provides more accurate provider information than conventional MA directories

73% of providers' address confirmed on Google Places; 72% in MA directories; 67% in CMS' NPPES file; and 65% in MR health insurance exchange directories.

Inaccuracies included

- Incorrect information for an in-network provider;
- OON providers listed as in-network providers; and
- In-network providers omitted.

Inaccuracies caused by

- A lack of consistent standards for provider information;
- Providers' failure to prioritize updating directory information; and
- Federal government's failure to develop a strategy to address inaccurate health plan directories.

CMS Provider Directory Review: Round 1

Provider Directory Review:

- Feb 2016 – Aug 2016
- 54 plans and 11,646 provider locations
- 5,832 providers total: cardiology, oncology, ophthalmology, PCP

45.1% of provider directory locations were inaccurate

- Percent of inaccurate locations for each plan directory ranged from 1.77% to 86.53%
- Average inaccuracy rate 41.37%

Inaccuracies included:

- Not at the location listed
- Incorrect phone number was incorrect, or
- Not accepting new patients

52 Plans subjected to Compliance Actions:

- 31 Notices of Non-Compliance
- 18 Warning Letters
- 3 Warning Letters with Request for a Business Plan

CMS Provider Directory Review: Round 2

Provider Directory Review:

- Sept 2016 – Aug 2017
- 64 plans and 14,869 provider locations
- 6,841 providers total: Top 10 MAOs + remainder by random sample

52.20% of provider directory locations were inaccurate

- Percent of inaccurate locations for each plan directory ranged from 11.20% to 97.82%
- Average inaccuracy rate 48.39%

Inaccuracies included:

- Not at the location listed
- Incorrect phone number was incorrect, or
- Not accepting new patients

53 Plans subjected to Compliance Actions:

- 22 Notices of Non-Compliance
- 19 Warning Letters
- 12 Warning Letters w/ Request for a Business Plan
- No action against 9 MAOs subject to compliance actions in prior round

CMS Provider Directory Review Round 3

Provider Directory Review:

- Nov 2017 – July 2018
- 52 plans and 10,504 provider locations
- 5,602 providers total: Newly eligible MAOs + top 10 MAOs + MAOs not previously reviewed

48.74% of provider directory locations were inaccurate

- Percent of inaccurate locations ranged from 4.63% to 93.02%
- Average inaccuracy rate 44.97%

Inaccuracies included:

- Not at the location listed
- Incorrect phone number was incorrect, or
- Not accepting new patients

40 Plans subjected to Compliance Actions:

- 18 Notices of Non-Compliance
- 15 Warning Letters
- 7 Warning Letters with Request for a Business Plan
- No action against 10 MAOs reviewed in prior rounds

CMS Review Results from Rounds 1-3

	Round 1	Round 2	Round 3
Review Period	Feb – August 2016	Sep 2016 – Aug 2017	Nov 2017 – July 2018
Number of MAOs	54	64	52
Number of Locations	11,646	14,869	10,504
Number of Providers	5,832	6,841	5,602
% Deficient Locations	45.10%	55.20%	47.74%
Range of Deficiency Scores for MAOs	1.77% to 86.54%	11.20% to 97.82%	4.63% to 93.02%
Average Deficiency Rate	41.37%	48.39%	44.97%
Number of MAOs with between 30% and 60% deficient locations	37	37	28

Implications of CMS Provider Directory Review

Findings not skewed by a few organizations but widespread—very few organizations performed well

> 85% deficient locations had egregious errors:

- Provider should not be listed at any of the directory-indicated locations
- Phone number needs to be updated
- Provider NOT accepting new patients

A minimum, increase members' frustration with plan

May also prevent sufficient access to care

Common Drivers of Deficiencies

Group practices provide data at the group level rather than provider level

- Can inflate number of locations where a provider practices
- Plans may need to push back against provider group requests

Lack of internal audit/testing by plans

- Credentialing services/vendors not a reliable means of ensuring accuracy
- CMS encourages routine oversite of processes for data validation

Reactionary approach to updating directories

- CMS found provider directories to be years out of date
- Plans must seek updated information from providers routinely
- Plans should use all data available (e.g., claims data) to id provider inactivity

Next Steps for CMS

- CMS will conduct an additional round of review
- A centralized repository for provider data is “a key component” for accurate provider directories
- 2020 Call Letter
  - Health plans cannot solve the inaccuracy problem on their own
  - CMS is exploring options for assisting MA plans and providers in identifying a single source for data
  - Encourages dialogue among stakeholders to provide further focus to the topic

Provider Directories: In the Courts

- **Blue Shield of California Affordable Care Act Cases (CJC-14-004800) (S.F. Cty. Super. Ct.)**
  - $23M settlement
  - Fined $350,000 in 2015
- **Harvey v. Centene (2:18-cv-00012) (E.D. Wa.)**
  - Class cert pending
  - Fined $1.5M in 2017
- **Kirby v. Anthem Blue Cross Blue Shield (1:19-cv-00597-ELR) (N.D. Ga.)**
  - Dismissed
  - Fined $250,000 in 2015
- **Desai v. CareSource (3:18-cv-118) (S.D. Ohio)**
  - Remanded to state court

Provider Directory: Takeaways

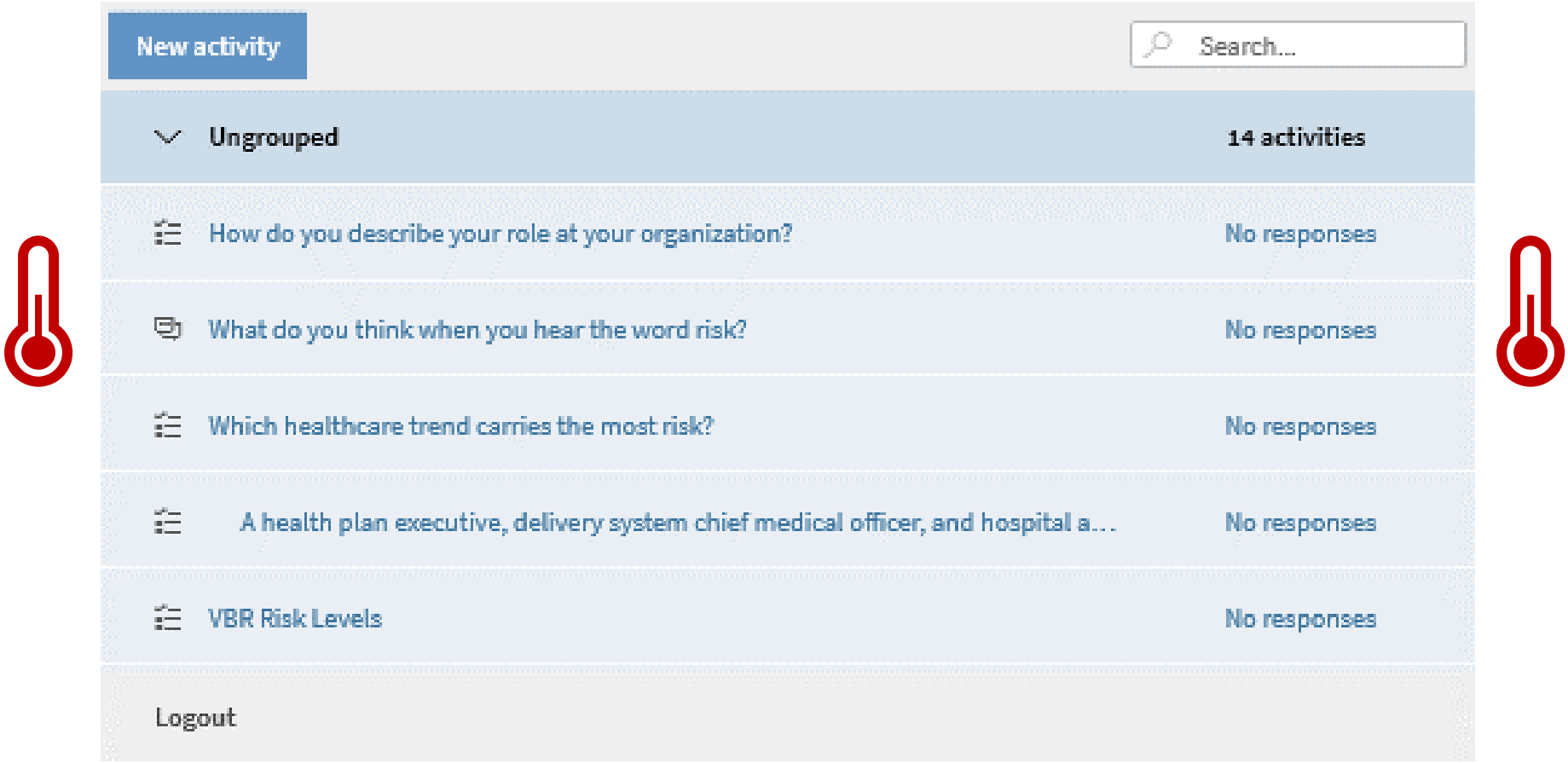
Challenges for Health Plans

- Provider dependent
- Litigation Risk
- CMPs and fines
- Political liability
- Potential for increased oversight and scrutiny

Risk Mitigation

- Watch for emerging best practices
- Take a hard look at marketing
- Clarify federal role
- Support efforts to create centralized data repositories
- Tailor efforts to CMS requirements

Provider Directories: Risk Thermometer



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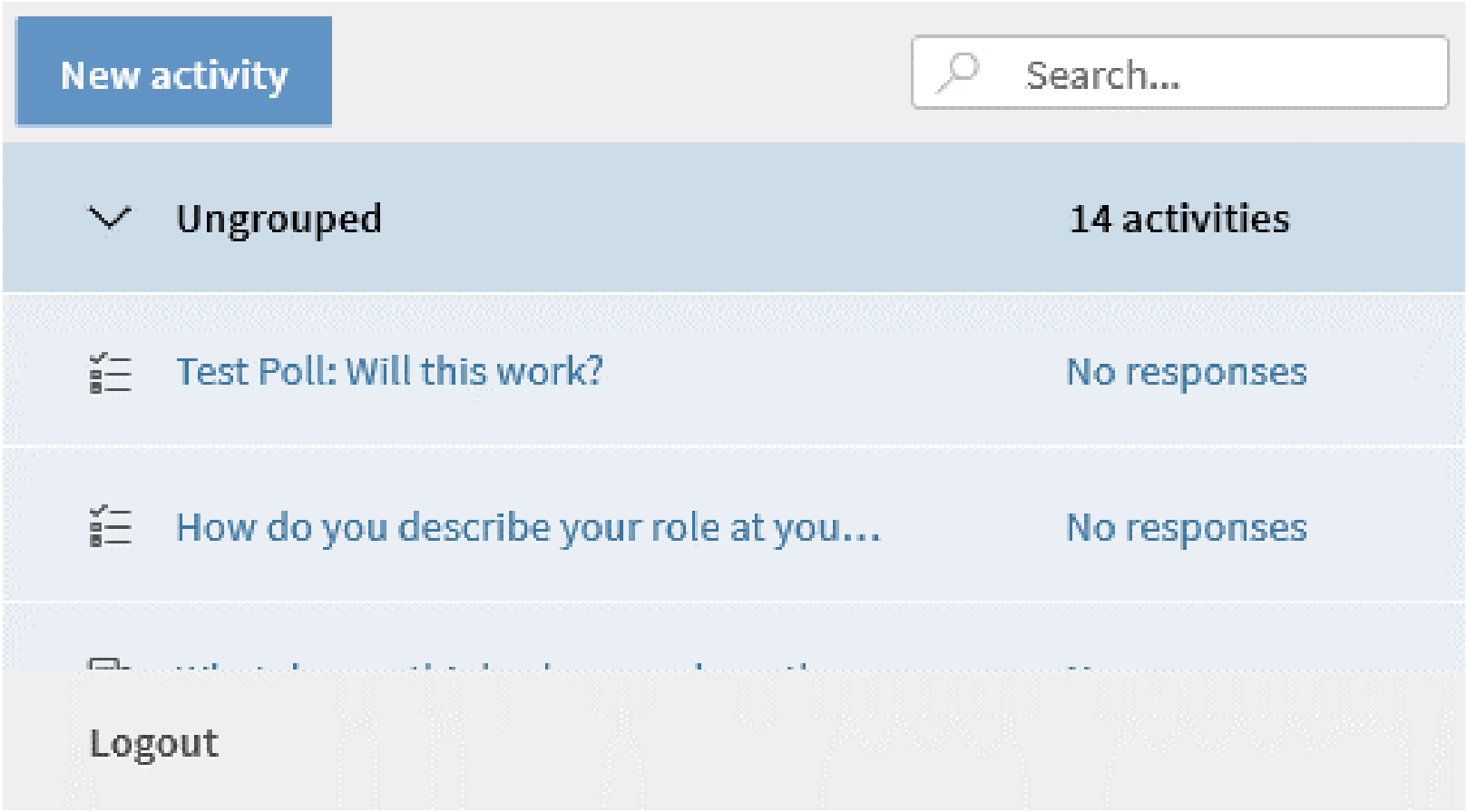
BALANCE BILLING

COMMON

CONSUMER-DRIVEN

CHALLENGING

Poll: How Many of Us Have Received Surprise Bills?



Balance Billing: What's the Problem?

- Nearly one in five inpatient admissions includes a claim from an out-of-network provider
- One in ten insured adults have received a surprise bill in the past year
- Average surprise bill more than $600
- 2/3 of Americans are "very worried" or "somewhat worried" about unexpected medical bills

Balance Billing: Federal Law

Private/Commercial Insurance: Federal law does not address balance billing

- No regulation of reimbursement rates
- No limits on provider billing
- No prohibition on balance billing

ACA emergency services rule

- Plan must reimburse a "reasonable amount" – greater of (1) UCR; (2) median in-network rate; and (3) 100% of Medicare reimbursement rate
- No prohibition on provider billing for unreimbursed charges.

Government programs

- Medicare: no balance billing for PAR; non-PAR may bill up to 15% MFS
- Medicaid: No balance billing
- MA: No balance billing for Medicare-covered services (unless private FFS)

Balance Billing: State Law

As of 1/2019, 16 states with partial protections and 9 states with comprehensive protections (CA, CT, FL, IL, MD, NH, NJ, NY, OR)

Colorado, New Mexico, and Texas strengthened protections in 2019

"Comprehensive" Protections include:

- Emergency departments and in-network hospitals;
- All types of insurance, including HMOs and PPOs;
- Hold-harmless for consumers;
- Bars providers from balance billing
- Includes a reimbursement standard or a dispute resolution process

25 states and DC without protections

NAIC Health Benefit Plan Network Adequacy and Access Model Act

Balance Billing: Proposed Federal Legislation

- **Sens. Alexander (R-TN) and Murray (D-Wash), Lower Health Care Costs Act (S. 1895)**
- **Reps. Pallone (D-NJ) and Walden (R-OR), No Surprises Act (H.R. 3630)**
- **Sen. Cassidy (R-LA), Stopping The Outrageous Practice of Surprise Medical Bills Act of 2019 (S. 1531)**
- **Rep. Ruiz (D-CA), Protecting People From Surprise Medical Bills Act (H.R. 3502)**
- **Rep. Doggett (D-TX), End Surprise Billing Act (H.R. 861)**
- **Sen Scott (R-FL), Protecting Patients from Surprise Medical Bills Act (S.1266)/Rep. Spano (R-FL) (H.R. 4223)**
- **Sen. Shaheen (D-NH), Reducing Costs for Out-of-Network Services Act of 2019 (S.967)**

Balance Billing: What the Courts Say

- ***Victory Mem'l Hosp. v. Rice*, 493 N.E.2d 117, 119-20 (1986)** – contract between patient and hospital was indefinite as to price, requiring proof that hospital's charges were reasonable
- ***Payne v. Humana Hosp. Orange Park*, 661 So. 2d 1239, 1241 (Fla. Dist. Ct. App. 1995)** – "A patient may not be bound by unreasonable charges in an agreement to pay charges in accordance with 'standard and current rates.'"
- ***Allen v. Clarian Health Partners, Inc.*, 980 N.E.2d 306, 308-11 (Ind. 2012)** – patient's agreement to pay "the account" referred to hospital's chargemaster rates and did not have an open price term, precluding the court from imputing a reasonable price
- ***Bowden v. Medical Center*, No. S14G1632, 2015 WL 3658819 (Ga. June 15, 2015)** – in dispute over validity of hospital charges patient challenging reasonableness is entitled to discover information relating to the amounts the medical provider charged other patients for similar care
- ***In re North Cypress Medical Center Operating Co. Ltd.*, No. 16-0851 (Tex. Apr. 27, 2018)** – hospital was required to disclose insurance reimbursement rates
- ***Centura Health Corp. v. French*, No. 2017-CV-030884 (Adams Cty. Dist. Ct., June 11, 2018)** – jury found that contract required patient to pay only reasonable value of hospital services and awarded hospital only $766.74 on $303,709.49 bill
- ***Bozarth v. Envision Healthcare Corp.*, No. 5:17-cv-01935-FMO SHK (C.D. Cal.)** – preliminary settlement includes write-off of outstanding balances for emergency services in excess of reasonable reimbursement determined by members' health plan

Balance Billing: A New Bargaining Chip

Envision v. United Healthcare, No. 0:18-cv-60530-UU (S.D. Fla.)

- March 2018 – Envision filed complaint challenging UHC's attempt to adjust ER contract rates downward
- May 2018 – Court ordered arbitration under the contract
- September 2018 – UHC sent advanced notice to 700+ hospitals that Envision could be out of network beginning January 2019
- December 2018 – UHC and Envision enter into a contract extension

Balance Billing: Takeaways

Challenges for Health Plans

- Threat of high OON bills → higher payment rates/premiums OR ER rates
- Litigation risk
- Reputational risk
- Provider cooperation
- Federal fix needed

Risk Mitigation

- Clarity in coverage documents
- Member education
- Build networks that deliver high quality care and value
- Support policy that encourages participation in high-value networks
- Collection practices

Balance Billing: Risk Thermometer

In Conclusion: Litigation is War!

"War is . . . nothing but a continuation of [politics/policy] [by] other means."

– Karl Von Clausewitz, On War

"The true object of war is peace."

– James Clavell, forward to the Art of War by Sun Tzu

Litigation is War!

Nation – Client/Health Plan/Provider

- Suffers the consequences/reaps the reward
- Establishes the purpose/goal

Superior Commander – Attorney

- Oversight and management of litigation
- Executes to achieve nation's goal
- Organizes and guide litigation-serves nation
- Strategy, operations and tactics defined by client's goals

Soldiers/Infantry – Witnesses

- Implements risk mitigation strategies
- Present facts to decisionmaker under guidance of attorney

Adversary – Competitor/Contract Partner/Vendor/Member

Litigation is War?

Military strategy – planning and execution of contest between armed adversaries

- Principal tool to secure national interests
- Distinct from national strategy
- Distinct from military tactics
- Using resources against opponent's resources to gain supremacy or reduce will to fight

Key Takeaways: Risk Mitigation

Diplomacy

- Pick up the phone!

Regional involvement

- Who is sitting at the table for corporate strategy and communications?
- Empower your team to act decisively

Emphasis on prevention rather than reaction

- Toxic work cultures – we only want good news!
- Objectivity – assess strengths and weaknesses dispassionately
- Create an environment of accountability and culture of compliance

Arms control/disarmament

- Dispute resolution provisions
- Tactical empathy

Key Takeaways: Dispute Resolution

- Objective
- Reconnaissance
- Surveillance
- Timing
- Attrition
- Divide and conquer
- Command and control

"No one starts a war--or rather, no one in his senses ought to do so--without first being clear in his mind what he intends to achieve by that war and how he intends to conduct it."

"The general who wins a battle makes many calculations in his temple before the battle is fought. The general who loses a battle makes but few calculations beforehand. Thus do many calculations lead to victory, and few calculations to defeat; how much more no calculation at all! It is by attention to this point that I can foresee who is likely to win or lose."

"In all history, there is no instance of a country having benefited from prolonged warfare. Only one who knows the disastrous effects of a long war can realize the supreme importance of rapidly bringing it to a close. It is only one who is thoroughly acquainted with the evils of war who can thoroughly understand the profitable way of carrying it on."

- Sun Tzu, Art of War

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"Moreover, every war is rich in unique episodes. Each is an uncharted sea, full of reefs. The commander may suspect the reefs' existence without having ever seen them; now he has to steer past them in the dark."

– CARL VON CLAUSEWITZ, ON WAR 86.

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