Litigating Managed Care Contract and Reimbursement Disputes

Strategies and Trends

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Litigating Recoupment of Underpayments

- Improper adjudication practices
  - Improper denials
  - Underpayments
  - Untimely payments (prompt pay review)
- Unnecessary administrative burdens (claim review projects)
Litigating Recoupment of Underpayments

• Identifying improper payment practices
  o Review of
    • hospital’s patient accounting system data
    • EOBs
    • UB-92s (now UB-04 or HCFA1500/CMS 1500)
    • Medical records
Litigating Recoupment of Underpayments

• Practices uncovered:

  o **Denials**: withholding and/or reduction in payment for medical (clinical) or administrative (technical) reasons.

  o **Downcoding**: reducing payment for medical (clinical) reasons to a lower level of care than billed for by the hospital.
Litigating Recoupment of Underpayments

 Practices uncovered, cont.:

- **Hidden Denial/Downcoding**: a denial/downcode that resulted in a reduction of payment but was not disclosed on the EOB through the use of clear, informative remittance codes.

- **Underpayments**: reductions for reasons other than denial and downcoding
Litigating Recoupment of Underpayments

- Expert witness provided denial software, denial recovery services, and assessment services.
- National average denial rate should not be higher than 4% for claims and 2% for days.
- In our case, the rate was 10.26% for claims and 5.47% for days, based on sample size of 380 claims.
Litigating Recoupment of Underpayments

- 87.83% of all denials reviewed met criteria and were not appropriate.

- 100% of technical denials involved a claim were med necessity was not in dispute.
Litigating Recoupment of Underpayments

• Takeaways:
  
  o With the current trends of declining reimbursement from Medicare and Medicaid, hospitals must rely on the agreements negotiated with MCOs to produce the margins attainable by the contracted rates.
  
  o Talk to billing department about developing a payor scorecard so that you can compare payor to payor on these types of performance issues.
  
  o Establish a joint resolution committee that meets quarterly to resolve issues.
  
  o Include reciprocating language for timely submission of claims that mirror the take back period for the payor.
Compliance with federal mandates

• Network Adequacy
  - Insurers are emphasizing narrow and tiered provider networks
    - Narrow: use a select group of participating providers
    - Tiered: use a select group of participating providers at a lower cost-sharing tier and a broader group of participating providers as a high cost-sharing tier

• Mental Health Parity
  - Financial requirements and tx limitations imposed on MH/SUD benefits cannot be more restrictive than the financial requirements and tx limitations that apply to substantially all med/surg benefits.
  - Separate financial requirements or tx limitations that are applicable only to MH/SUD benefits are also prohibited.
Federal Network Adequacy Requirements

• Affordable Care Act: Each Qualified Health Plan ("QHP") provider network sold on an Exchange must:
  o Meet the general network adequacy requirement;
  o Include “essential community providers”; and
  o Be consistent with the network adequacy requirements of the Public Health Services Act.

45 C.F.R. § 156.230
Federal Network Adequacy Requirements

• A QHP insurer must maintain a “network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.”

45 C.F.R. § 156.230; 77 Fed. Reg. 18310, 18418 (March 27, 2012)
Federal Network Adequacy Requirements

- Essential Community Providers ("ECP")
  - Serve predominantly low-income, medically underserved individuals
  - A QHP issuer “must have a sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP’s service area, in accordance with the Exchange’s network adequacy standards.”
  - A QHP issuer is not required to contract with an ECP if the ECP “refuses to accept” the issuer’s “generally applicable payment rates.”

45 C.F.R. § 156.235
Federal Network Adequacy Requirements

- CMS enforces these requirements for federally facilitated exchanges.
- Beginning 2015, CMS will assess provider networks using a more stringent “reasonable access” standard, and will identify networks that fail to provide access without unreasonable delay.
- CMS will focus on areas that have historically raised concerns, including:
  - Mental health providers
  - Oncology providers
  - Primary care providers
  - Hospital systems

Federal Network Adequacy Requirements

• If CMS determines that an issuer network is inadequate, it will notify the issuer of the problem areas and will consider the issuer’s response in assessing whether the issuer has met the regulatory requirement prior making the certification or recertification determination.
State Network Adequacy Requirements

- State Insurance Commissioners are tasked with enforcing network adequacy laws for non-federal exchanges.
- Connecticut’s 2014 Legislative Session
  - Senate Bill 392- DID NOT PASS
State Network Adequacy Requirements

- SB 392 would have required annual reports from insurers regarding each of their plans, the number of enrollees and the number of in-network providers.
- It also would have required Commissioner and Healthcare Advocate to conduct actuarial analysis of provider network adequacy of each insurer/HMO/PPO.
State Network Adequacy Requirements

- SB 392 would have prohibited an insurer from excluding from its network any appropriately licensed type of health care provider as a class
- If actuarial analysis determined that network was not adequate, the insurer/HMO/PPO would be required to survey providers and enrollees on issues relating to access, and the Commissioner would examine the contracting policies of the insurer and interview enrollees about ability to get appointments
Network Access Litigation

  - United issued notices to over 2,000 CT physicians that they would be terminated effective February 1, 2014 from their Medicare Advantage Network.
  - The physicians sought an emergency motion for a temporary restraining order and preliminary injunction seeking to enjoin United from terminating them.
Fairfield Cnty. Med. Ass’n cont.

- The physicians alleged that United had denied their substantive and procedural due process rights under the Medicare Act, 42 U.S.C. §§ 1305 et seq., and United had breached the individual contracts with each terminated physician.

- The parties primarily disagreed about whether an insurance company providing Medicare Part C coverage may unilaterally remove, without cause or consent, any physician in its network.
  - The Physician Contract’s amendment clause offers United broad discretion to unilaterally alter its agreements with physicians, allowing amendments to take place so long as United provides at least 90 days’ notice.
The district court, Underhill, J., granted the injunction.

The Second Circuit Court of Appeals affirmed on February 7, 2014 after an expedited appeal.
Network Access Litigation

- **In re Seattle Children’s Hospital, No. 13-2-34827-6, Wash. Sup. Ct., King Cnty.**
  - Hospital lawsuit against the state’s Insurance Commissioner challenging its approval of the hospital’s exclusion from certain exchange networks.
  - Hospital alleged that the Commissioner failed to follow existing law and abused its discretion in approving the exchange plans at issue without network adequacy.
In re Seattle Children’s Hospital, cont.

• Hospital alleged it was the only pediatric hospital in King County and preeminent provider in many pediatric specialty services in the Northwest, some of which are not available elsewhere.

• Hospital further alleged that the Commissioner’s decisions were not in compliance with 42 USC § 18031(c)(1)(C), which requires qualified health plans to include with their plan networks “essential community providers” which are defined to include hospitals.

• A Stipulation and Order of Dismissal was entered on April 17, 2014.
Network Access Litigation

Takeaways:

1) We anticipate more disputes over network participation over the next few years, especially with Exchange networks.

2) Fairfield Cnty. Med. Ass’n serves as a reminder during the contract negotiation phase to pay attention to inequality of rights under the amendment and termination provisions.
Mental Health Parity Issues

• More thorough/aggressive/onerous medical necessity review for mental health treatments
• Lack of clear mental health necessity criteria
• Higher copays for mental health services
• Lack of in-network mental health providers because rates are very low compared to rates paid to medical/surgical providers – patients forced to pay high fees out-of-network or go without care
Federal Mental Health Parity

- Mental Health Parity and Addiction Equity Act (Act) requires many insurance plans that cover mental health or substance use disorders to offer coverage for such services that is no more restrictive than the coverage it offers for medical/surgical conditions. Includes copays, coinsurance, out of pocket maximums, limitations on utilization of services, coverage for out-of-network providers, medical necessity criteria, etc.
Federal Mental Health Parity, cont.

- Note Act itself does not require any insurance plan to cover mental illnesses or substance use disorders.
- Act does not apply to non-federal governmental plans that have 100 or fewer employees or employers with fewer than 50 employees; however, ACA extends Act’s requirements to the small group and individual markets.
  - Qualified Health Plans sold on Exchanges must include coverage for mental health and substance use as a category of essential health benefits.
Connecticut Mental Health Parity

- State law provides for mandatory coverage for diagnosis and treatment of mental or nervous conditions in individual and group health insurance plans and prohibits policies from establishing terms or conditions that place a greater financial burden on an insured to diagnose or treat a mental or nervous condition than for diagnosis of a medical or other physician condition.
Mental Health Parity Litigation - Connecticut

- Involved in litigation in U.S. District Court in Connecticut against Anthem Health Plans, Inc. d/b/a Anthem Blue Cross and Blue Shield of Connecticut and parent company, Wellpoint, Inc.

Suit alleges Anthem companies violated the federal Act and provider agreements by applying formulas and methodologies for determining reimbursement rates for psychiatric physician services that are not comparable to, and are applied more stringently than, the formulas and methodologies for determining reimbursement to non-psychiatric physicians.

- Alleges that in doing so, companies violated their obligations under ERISA as plan providers and fiduciaries, breached their contracts with network providers and tortiously interfered with the relationships between psychiatrists and their patients and patients and their health plans.
Litigation Status

• Anthem companies filed a Motion to Dismiss the complaint; oral argument took place in April 2014.

• On September 25, 2014, the court granted Anthem’s Motion to Dismiss.

• On October 24, 2014, an appeal was taken to the Court of Appeals for the Second Circuit.
Mental Health Parity Litigation – Other States

- Litigation in a number of other states (VT, CA, NY)
- Vermont – First federal court to rule on interpretation of Act
  - Court found in favor of plaintiff who alleged that the insurer violated the Act by requiring preapproval for mental health services but not medical services, by conducting concurrent reviews of mental health services but not medical services, and by using an automatic review processes set in motion by a fixed number of visits for mental health services but not for other medical services (C.M. v. Fletcher Allen Health Care Inc.)
Mental Health Parity Litigation

• Takeaways:
  o Parity will continue to be an issue because patients are hesitant to step forward as the poster child for mental health and/or lack the resources to fight this battle.
  o Need the right plaintiff: only parties specifically enumerated in ERISA (plan participants, Need the right defendant: plan.
  o Need legislative overhaul to make it easier for providers/associational plaintiffs to bring suit under ERISA.