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Feeling the Squeeze – Navigating Managed Care Network Participation

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Speaker Introduction

- Representing health care providers exclusively for the past 20 years

- Former federal prosecutor, chief compliance officer for state mental health agency, and attorney at national law firms in DC and Philadelphia

- Represent health systems, hospitals, large physician groups, ambulatory surgery centers, and residential and community-based behavioral health providers

- Negotiate managed care contracts, collect unpaid and underpaid reimbursement claims, respond to refund demands from payors, and provide regulatory advice

- Represent providers across the country offering all types of addiction recovery services – drug and alcohol, detox, residential, partial hospitalization, intensive outpatient, traditional outpatient, and sober living
Presentation Agenda

- Introduction: Network Participation
- Repricing entities for OON services
- Direct-to-employer contracting by providers
- Narrow networks/provider risk sharing
- OON rules and challenges
- Contracting and payment
- ERISA preemption of provider actions against insurance plans
INTRODUCTION: NETWORK PARTICIPATION
Intro: Feeling the OON payor squeeze

- The Old Days (non-emergency OON services)
  - Providers sought billed charges, as always
  - Payors paid claims using an allowable amount based on usual and customary rate
- Usual and Customary rate (UCR)
  - Approximation of what is generally paid for comparable service in geographic area
  - Disputes over calculation of UCR (e.g., Ingenix case)
  - Bottom line was still that getting OON payment was harder, but amount was higher
- The New Normal
  - Reference-based pricing (e.g., percentage of Medicare FFS rate)
  - Pre-pay review/Flags – targeted segments (ASCs, addiction recovery providers)
Intro: Constraints on Payor Pricing

- Payor needs to offer sufficient network of providers
- Consequences of using lower allowable amounts
  - Payor pays less of provider’s billed charges
  - In addition to higher OON cost share, member may face big balance bill
  - Alternatively, provider that doesn’t want to send and/or rely on collecting big balance bills may refuse to see plan members
- Pressure on employer plans and third party administrators
  - Members paying more for OON benefits that prove harder to use
  - Fewer providers agree to provide OON services; those who do may send big balance bill, causing members to complain to plan administrator
Whether to Accept Federal Health Program Patients?

- Anti-Kickback Statute, Stark Law, Civil Monetary Penalties, False Claims Act
- Oversight by HHS OIG, and State Attorneys General and MFCUs
- Contracting with Medicare Advantage plans and Medicaid MCOs
  - The participation agreement makes a difference, not identical to treating members of fee-for-service programs
  - Managed care is within the scope of government oversight
  - Know terms of plan’s contract with CMS/single state agency
Intro: Whether to Join Commercial Health Plan Networks?

- **Old calculus**
  - Go in-network, get paid less, try make it up in volume
  - Stay out-of-network, get paid more, often make more money doing fewer/higher paying cases than by joining network

- **New calculus**
  - Go in-network
    - Will payor extend an offer? Is there an “any willing provider law” that applies? NJ law re pharmacy
    - Low network rates might not be enough, even with higher member volume
    - Unintended consequences – e.g., the Blue Card program
  - Stay out-of-network
    - Payors are slow to pay
    - Payors pay less – e.g., reference-based payment (e.g., 110% of Medicare) instead of 80% of UCR (e.g., estimate of average rate paid for same services in same geographic area)
    - Payors pay consumers instead of providers, regardless of valid patient assignment
Repricing Entities for OON Services (like MultiPlan, Genex)
Repricing Entities: How Do They Work?

- Middle ground between in-network and OON service
- Repricing entity contracts separately with payor and provider
  - Provider agrees to accept (e.g.) 60% of billed charges as payment in full when it sees members of OON plan who have (e.g.) MultiPlan logo on their insurance cards
  - Payor agrees to pay amount agreed-upon by MultiPlan and OON provider when its members go to that provider for care on an OON basis
- Repricing arrangements may constitute both an independent promise to pay and a defense to fraud and misrepresentation claims
Repricing Entities: What’s Enforceable?

- Payors seek to retain discretion as to whether use repricing in specific cases
  - Just because member has MultiPlan logo on insurance card, doesn’t mean that payor will choose to pay claim through repricing entity
  - Phone representative for insurer may allude to repricing agreement when verifying benefits
  - Provider doesn’t know for sure until it receives Explanation of Benefits
- Repricing agreement with provider may have specific relevant provisions
  - May not require provider to collect full OON-level patient cost share
Repricing Entities: Enforcement Mechanism?

- States differ as to whether MultiPlan/Provider/Payor agreements create one enforceable contract
  - *The Plastic Surgery Ctr., P.A. v. Cigna Health & Life Ins. Co.*, No. 17-2055 (FLW) (DEA), 2018 Us Dist Lexis 90422, 2018 WL 2441768 (D.N.J. May 31, 2018) (refusing to dismiss a plaintiff medical provider’s breach of contract claim against a health insurer, where the provider and insurer had not directly contracted with one another, but had each contracted with MultiPlan)
Direct-to-Employer Contracting
Direct-to-Employer Contracting

- Create provider network through direct contracts
  - Bypasses insurance companies/conventional third party administrators.
- Create network of specialists or specific care providers (i.e., imaging)
- Bundled payments
Direct-to-Employer Contracting – Examples

**Boeing**
- Provider group organized as ACO with quality, access, and savings targets
  - 9 hospitals, 2,400 physicians and other providers, plus 71 surgery centers, urgent-care facilities and other clinics
- Offered to employers in open enrollment, along with traditional plans
- Claims processed through traditional insurance company

**Lowe’s**
- Direct contract with Cleveland Clinic for cardiac care
- Bundled payments for certain surgical procedures
- Bundled price includes all costs including travel
- Procedures are free for employees
Health Transformation Alliance

WE’RE THE HTA

A group of 40 plus major corporations that have come together in an alliance to do one thing: fix our broken healthcare system.

6M+ lives covered

$25B annual spend
Health Transformation Alliance

- When formed in 2016, estimated 20 members and $600 million in savings over 3 years compared with current drug-benefit contracts, starting in January 2018
  - Saving represent 14% - 15% of total drug spending for the employers

- Program focuses on:
  - Drug purchasing
  - Using data to understand trends and results, and predict/prevent disease, improve outcomes, and increase value for members
  - Enabling integration and collaboration among stakeholders

- Program includes contracts to purchase drugs through CVS/Caremark and OptumRx, the creation of specialized physician networks, and the use of IBM’s Watson to analyze healthcare data.

[Links to additional resources]

HTA: Current Status and News (2019)

- 50 plus major corporations; 7 million plus lives covered; and $27B in annual spend
- Members include major companies like American Express, HCA, Verizon, DuPont, and Marriott
- November 2018 – HTA partnered with Rx Savings Solutions to serve as the alliance’s preferred vendor for “innovative prescription savings software that empowers employers and employees to become better healthcare consumers”
- March 29, 2019 Workforce Magazine article – quotes HTA CEO Rob Andrews regarding setting right incentives for health care system
  - Andrews advocates looking not just at price but also at value of services
  - Example of Medicare paying more to radiology provider that does higher volume of imaging but makes more mistakes, versus radiology provider that does lower volume of imaging but makes fewer mistakes
  - Surgery center client example – not rewarded for savings because procedures are more expensive
Narrow Networks/
Provider Risk Sharing
Narrow Networks: Plan Perspective

- Another level of participation in network contracting
  - In-network versus out-of-network: Contracting through repricing entity (like MultiPlan)
  - In-network versus out-of-network: In-network but not in preferred tier of network (like Horizon BCBSNJ Omnia program)

- Plan may seek to add new networks, subnetworks, or lines of business
  - Wants to dictate which of its network providers will be included and on what terms
  - Wants plan discretion to extend beyond just determining which providers are qualified to participate in new network/new product
  - Wants to incentivize plan members to use preferred tier in-network providers (offer lower cost share payments to members to do so)
  - Wants to shift at least some financial risk to preferred tier providers
Narrow Networks: Provider Perspective

- Provider wants to preserve same access to plan members it negotiated at start for life of network agreement
  - Right to join or not join new network/new product
  - Right to participate in new network/new product on advantageous terms
  - Right to ensure those terms are no worse than those given to comparable network hospitals
- Provider wants benefit of cost savings
  - Share in cost savings incentive programs
  - But limit financial risk (e.g., start by having upside risk only)
OON Rules and Challenges
Network Management

- The Issue
  - To what extent can payors dictate terms on which providers render services to the payor’s members on an OON basis?

- What Payors Want
  - To attract members by getting providers into payor network and by offering OON benefits
  - To keep costs down by steering patients in-network

- What Providers Want
  - To stay OON if payors are not offering competitive rates
  - To attract members of OON plans
Provider Networks

- Health insurance plans contract with “participating” providers
  - Providers accept less than charge description master (CDM) charges
  - Plans direct volume to providers
- Plan benefits and structure
  - May include coverage for in-network and OON services
  - Members typically pay higher premium to get OON coverage
  - Amount patient has to pay (“patient cost share”) usually higher for OON services versus in-network services
  - Serves as incentive for patients to stay in-network
**Payment for Services**

- Member typically assigns insurance benefits to provider

- Provider paid by insurer
  - If in-network, paid contracted amount
  - If OON, paid “allowable amount” set by insurer
    - Usual and customary amount
    - Percentage of Medicare
    - Percentage of charges (especially if services are through repricing entity, like Multiplan)

- Provider paid by patient as well
  - Copay – fixed-dollar amount paid for each service
  - Deductible – fixed-dollar amount patient must contribute to type of care in given coverage year before benefits start
  - Coinsurance – percentage of amount set by insurer
Discount OON Patients’ Cost Shares?

- To compete for patients, OON providers may discount patient cost share amounts (i.e., absorb the OON penalty)
- Typical arrangement: provider treats OON patient as if he/she is in-network
- How disputes arise
  - A plan’s special investigations unit conducts an audit
  - Pre-payment audits may lead to withholding all payment for services or paying only amount corresponding to patient cost share estimated by provider
  - Post-payment audits may lead to repayment demand, offsets, and/or putting flag on provider
Legal Prohibitions on Discounting Patient Cost Share

- **Federal laws**
  - Federal Anti-Kickback Statute/ Ban on Inducements to Beneficiaries
  - No discounts to members of:
    - Medicare FFS and Medicaid FFS
    - Medicare Advantage plans (often grouped together with commercial plan members for contracting purposes)
    - Medicaid managed care plans

- **State laws**
  - Generally
    - Prohibit the routine “waiver” of cost share amounts as an inducement to select a particular provider
    - May still allow “discount” of patient cost share
    - Allow for case-by-case waivers for financial need, but create presumption of violation if waivers too frequent
  - Most states do not have definitive prohibitions, but New Jersey and some other states do
    - Prohibitions on waiver of cost share statutes in New Jersey, Colorado, Florida, Georgia, and Texas
    - Other states have statutory protections for patients (e.g., Connecticut, Illinois, and New York) and providers (Texas) related to the use of OON services
New State Law (Part I)

  - The OON Law applies to fully-insured commercial plans and those self-funded employer plans that elect to be subject to it
  - OON provider may not bill patient for inadvertent (i.e., rendered by OON provider at an in-network facility), emergency, or urgent care:
    - More than in-network patient cost share amount
    - Balance between allowed amount paid by insurance and billed charges (i.e., balance bill)
  - If provider and plan cannot agree on amount for plan to pay for out-of-network services, they must then engage in a baseball-style binding arbitration
    - Arbitrator ultimately will order the plan to pay – and the provider to accept – either the amount put forward by the plan or the amount put forward by the provider
    - Could dramatically reduce provider leverage – no longer getting higher OON payments for emergency care
New State Law (Part II)

- OON Law also prohibits an OON provider from discounting the patient cost share owed by a health plan member for a covered service (N.J.S.A. 26:2SS-15)
  - Broadly worded prohibition: “It shall be a violation of this act if an out-of-network health care provider, directly or indirectly related to a claim, knowingly waives, rebates, gives, pays or offers to waive, rebate, give or pay all or part of the deductible, copayment, or coinsurance owed by a covered person pursuant to the terms of the covered person’s health benefits plan as an inducement for the covered person to seek health care services from that provider”
  - Commissioner of Banking and Insurance to issue regulation to the effect that pattern of waiving, rebating, giving or paying all or part of the deductible, copayment, or coinsurance by a provider will be considered a prohibited inducement
  - Why is this part of a consumer protection law?
New State Law (Part III)

- DOBI issued Bulletin No. 18-14 on November 20, 2018 to help carriers and providers meet their obligations under OON law pending formal regulations
  - Procedures for claims processing and arbitration
  - Reiterates that OON providers can still offer waivers, rebates etc. that:
    - Fall within safe harbor under federal laws related to fraud and abuse
    - Are not routine, advertised, or solicited, or and are based on patient’s financial need
  - Bulletin also notes that waiver of cost share is different from failure to collect after reasonable, good faith efforts
    - And, reasonable efforts do not mandate using a collections agency
New Federal Law

- On October 24, 2018, President signed the **Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act** a/k/a the **“SUPPORT Act”**
  - **Ant-kickback provision**
    - Prohibits the solicitation or payment of remuneration in exchange for referring a patient or patronage to a recovery home, clinical treatment facility or clinical laboratory, regardless of whether the benefits will be paid by federal, state or private payors
    - Violations of the new kickback prohibitions punishable by criminal fines of up to $200,000 per occurrence, up to 10 years in prison, or both
    - Safe harbors are similar to federal AKS, but not identical
  - **No rules promulgated yet**
    - SUPPORT Act prohibits “referring a patient” in exchange for remuneration
    - Does not extend to “arranging for referrals,” like federal AKS
    - Unclear if law will preclude common practice of addiction recovery facility paying productivity bonuses to representatives who market to commercial insurers
  - **Other notable provisions**
    - Loosens Medicare restrictions on telehealth services designed to treat substance abuse
    - New grants to establish or operate 10 “comprehensive opioid recovery centers” across the country (focusing on drug treatments (e.g., methadone), counseling, residential rehabilitation, and job-placement assistance)
Operational Considerations: Referrals

- Physicians referring to OON facility in which he or she may have ownership interest
  - If physician has professional network agreement, payor may argue that referral breaches that agreement
  - Typically, such agreements require physician to refer to in-network facility “consistent with sound medical judgment”

  - Jury awarded total damages of $37,452,199, not allocated among the causes of action, in favor of Aetna on all counts
  - Three physician owners of management company, BASM, each of whom held separate ownership interests in, and/or had referral, rental, or consulting arrangements with, the individual ASCs managed by BASM
  - Aetna offered evidence that the individual physician investor’s use of a BASM facility drastically increased after he or she purchased an investment interest in the facility. Aetna calculated this increase in BASM facility fees as moving from 9.33 percent to 77 percent.
  - Letters from facility to investors telling them to refer more cases, including specifically PPO cases, to the ASCs
Operational Considerations: Sufficiency of Notice of Discount

  - Cigna alleged that the ASCs dramatically reduced and/or waived patients’ copayments to induce them to use the ASCs, but then charged Cigna inflated rates for the same services
  - Dismissal of fraud claims where ASC provided notice through disclosures on claim forms
  - Cigna admitted knowledge of claim form stamping

  - Court permitted Cigna’s fraud-based claims to survive even though the ASC stamped its claims similarly to the ASCs in the **Arapahoe** case
  - Court believed stamp did not provide sufficient information regarding the extent of the discount
Operational Considerations: Good Faith Effort to Collect

- OON provider must make good faith effort to collect patient cost share
- Payment cannot turn on actual collections
  - *Garcia v. Health Net of New Jersey, Inc.*, No. C-37-06, 2009 WL 3849685 at *3 (N.J. Super. Ct. App. Div. Nov. 17, 2009) (affirming a decision by a trial court on summary judgment in favor of a provider that did not collect cost share amounts from plan members, noting that at the time the facility submitted its claims to the plan, the facility “did not know whether it would enforce the subscriber’s agreement to pay co-insurance”)
  - Compare with *Kennedy v. Conn. Gen. Life Ins. Co.*, 924 F.2d 698 (7th Cir. 1991) (holding that provider must collect co-payments “or at least leave the patient legally responsible for them” in order to collect money from an insurer who requires cost share)
Out-of-Network Issues (Part I)

- Facility flags
  - Statutory and contractual prompt payment periods still apply
  - Note privacy issues for addiction recovery providers
    - For example, the Pennsylvania DHS’ Department of Drug and Alcohol Programs’ interpretation of 4 Pa. Code 255.5
    - Limits medical record information a provider can furnish to a health insurance plan regarding substance abuse treatment, even with patient consent and for purposes of getting paid
Out-of-Network Issues (Part II)

- Patient cost share payments
  - No discounts to OON members of Medicare Advantage of Medicaid MCO plans
  - Some states also prohibit discounting patient cost share for member of an OON commercial plan
  - In remaining states, either charge full OON level cost share or notify payors that you are not doing so

- Patient balance billing
  - Some payors say they “require” an OON provider to collect from patient the difference between billed charges and allowable amount paid by the insurer to the provider
  - No court has to our knowledge ever conditioned provider’s right to insurance payment on balance billing patient
CONTRACTING AND PAYMENT
Negotiating Commercial Health Plan Agreements

- Extent to which a provider can negotiate contract terms and rates depends on various factors, but always worth trying to address key issues

- Sample key provisions
  - Plan’s right to recoup by offset
  - Prompt payment period language (applicability, or not, of state prompt payment laws)
  - Plan’s right to unilaterally amend agreement and/or incorporated provider manual
  - Applicability of contract rates at new facilities
  - Plan’s right to create preferred tiers of contracted providers and/or to direct plan members to certain network providers over others
Getting Paid (Part I)

- If you don’t make a record of a service, it didn’t happen
- More unusual an addiction treatment modality, more important that it be
  - Described in current treatment plan
  - Documented by clinician
Getting Paid (Part II)

- Filling out claim forms – issue of behavioral health claims misrouted as medical claims (due to type of rendering clinician?) and then erroneously denied
- Bill for level of service actually provided – insurers may well deem billing for “only” PHP when providing residential services, for example, as giving patient an improper inducement to come to your facility and as fraud
Appealing Payment Denials

- Mechanism in place to challenge all questionable denials
  - Chance to overturn denial and get paid
  - Only way to reserve right to bring legal challenge (prove “exhaustion of administrative remedies”)

- Checklist for denial appeals
  - Make sure appeal is timely and sent to correct address
  - Make sure appeal responds to actual denial reason
  - Pursue all available levels of appeal

- Wit v. United Behavioral Health (Case No. 3:14-cv-02346) and Alexander v. United Behavioral Health (Case No. 3:14-cv-05337) – March 5, 2019 decision by U.S. District Court in California finding that UBH unit’s internal guidelines for mental health and substance abuse coverage ignored generally accepted standards of care and focused on “crisis stabilization” while leaving patients stranded over the long term.
Responding to Refund Demands (Part I)

- Not all failures to abide by contract and manual provisions result in an obligation to refund payment
- False Claims Act applies to all federal health care programs
  - Potential overpayments from Medicare Advantage plans and Medicaid MCOs, as well as from fee-for-service programs
  - Even if initial overpayment resulted from innocent mistake, failure to report and refund identified overpayment could be violation of FCA
  - Treble damages and up to over $25,000 penalty per false claim
Responding to Refund Demands (Part II)

- Consider alternative ways of documenting that services were provided if standard records are insufficient

- Note limitations on plans’ legal rights of offset

  - For example, 2017 decision by federal district court in Minnesota – *Peterson v. UnitedHealth Group Inc. et al.* (Case No. 14-CV-2010) and *Riverview Health Institute v. UnitedHealth Group Inc. et al.* (Case No. 15-CV-3064)

  - *Peterson* rejected cross plan offsetting, which is when a TPA withholds current payment owed to provider for services rendered to member of TPA client/self-funded employer A’s plan so as to recoup amount of prior alleged overpayment to same provider for services rendered to member of TPA client/self-funded employer B’s plan

  - Affirmed by U.S. Court of Appeals for the 8th Circuit on Jan. 15, 2019
ERISA PREEMPTION
ERISA Overview

- What is ERISA and what does it preempt?
  - Federal statute created to bring stability and accountability to employee (health) benefit plans
  - ERISA Section 514 preempts any state law to the extent that it relates to any employee benefit plan
  - ERISA does not preempt state laws regulating insurance
  - A self-funded employer plan is not deemed to be an insurance company (thus subject to ERISA and not state law)

- Who can bring an ERISA claim?
  - Participant or beneficiary
  - Provider on assignment by participant or beneficiary

- Is there an anti-assignment provision in policy? Is it enforceable?
- Plans generally held to an abuse of discretion standard under ERISA (but not always)
**ERISA: Complete Preemption**

- A jurisdictional doctrine that provides for removal of a case filed in state court to federal court
  - Exception to well-pleaded complaint rule
  - ERISA found to exclusively “occupy the field” and therefore displace state law cause of action by plaintiff beneficiary seeking to recover benefits under plan
  - Transformed into case arising under federal law
  - Beneficiary could have brought claim under ERISA Section 502(a)(1)(B); and
  - No other independent legal duty implicated by defendant’s actions
ERISA: Conflict Preemption

- An affirmative defense to a state law cause of action
  - Applies when a state law claim “relates to” an ERISA plan under Section 514’s express preemption provision
  - Issue is whether state law claim “has a connection with or reference to” an ERISA plan

- Potentially relevant factors
  - Out-of-network versus in-network (claim based on separate network agreement)
  - Right to payment versus rate of payment (rate not dictated by ERISA plan)
  - Payment obligation derived solely from benefits plan versus independent promise (single case agreement scenario)
Thank you

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