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Tips for Managing Large Claims Disputes

Part 1: Pre-Litigation Avoidance and Early Litigation Strategies

By: Ed Brooks, Steve Hamilton & Jason Mayer

Large claims disputes brought by providers against payers are on the rise. Based on previous experience with dozens of these cases, this two-part article provides practical advice for in-house counsel on dealing with them, from pre-litigation avoidance strategies to trial.

Pre-Litigation Avoidance Strategies

The provider's standard playbook is to send a spreadsheet to the payer that lists basic accounting information but lacks claims-specific information, such as claim number and service information. The best avoidance strategy starts with the provider contract, the plan's provider manual, and the plan's policies and procedures.

Specifically, review provider contract templates closely for commonly contested issues, such as: (1) whether the plan or the provider determines medical necessity for purposes of payment; (2) prior authorization and notice requirements, especially for emergency inpatient admissions; (3) appeals and dispute requirements; (4) utilization management requirements; and (5) payment methodology and rates.

For non-ERISA plans, one of the most important contractual provisions relates to appeals and steps a provider must take before bringing a lawsuit. Courts and arbitrators may be reluctant to enforce appeals requirements absent clear and concise contractual language, so consider adding language stating that the provider must appeal or dispute claims issues, including payment disputes, and that the provider waives any right to bring litigation if it fails to do so. This allows the plan to argue that the provider failed to exhaust its remedies and failed a condition to bringing suit. Note, too, that since provider contracts can be heavily negotiated, provider manuals often are the best place to insert this type of language. But it is imperative that the contract expressly incorporate the provider manual, as updated from time to time.

It's also essential to perform a good preliminary analysis. This is easier said than done, given the potential resources needed; however, options exist, including identifying a random sample of the claims (such as by the special investigations unit or department that should have software available to determine a statistically valid sample) or focusing on the large-dollar claims.

Regardless of the approach chosen, the most important thing is getting a true analysis, as opposed to a perfunctory claims pull that merely identifies whether the claim was paid or denied. Instead, consider peeling back the layers of the onion, including examining the entire claims history (duplicate claims, resubmitted claims, etc.); whether the provider is providing information on the actual claims submitted, versus updated claims information; payment rate; and the line items for each code billed. This will provide real information to discuss with the provider. As an example, provider claims dispute spreadsheets often contain service

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information that was never billed to the plan or a duplicate claim that was never identified by the provider as such.

Early Litigation Strategies

Once the lawsuit is filed, the threshold issues are knocking the case out early and determining whether a counterclaim exists. For an early dispositive motion, potential arguments will depend on the type of plan and the particular jurisdiction, but the primary arguments are: (1) lack of standing or no private cause of action; (2) failure to exhaust administrative or contractual remedies; (3) pre-emption; and (4) existence of a binding arbitration clause.

In addition, if a summary complaint fails to allege facts for each claim, do not necessarily accept it. Instead, consider whether to move to dismiss it for failure to state sufficient facts demonstrating what amounts to thousands of alleged breaches. This approach is particularly appropriate in fact-pleading jurisdictions like Illinois. Although winning the motion is the goal, an early motion also presents an opportunity to provide important background information about the claims adjudication and payment process. Attacking the complaint early also educates the judge or panel. The argument is that weeding out the bad claims early benefits the court and streamlines the proceeding.

In terms of potential counterclaims, consider whether the plan has any potential recoveries against the provider. Recoupment should be the first consideration because money in hand is better than a demand. That said, many states have temporal restrictions on recoupments that limit the lookback period. Still, consider other potential causes of action, such as breach of contract, fraud, or unjust enrichment. Providers often argue that the recoupment statute limits the recovery period for all claims, but the reality is that the statutes usually are limited to recoupments by offset and they do not somehow pre-empt statutes of limitation for other causes of action.

In the next issue of McGuireWoods' *Managed Care Quarterly*, look for Part 2, discussing practical tips for discovery, dispositive motions and trial.

RECOVERY STRATEGIES

Lessons on Statistical Sampling From 5th Circuit's *Maxmed* Decision

By: Jeff Clark & Brett Barnett

In *Maxmed Healthcare Inc. v. Price*, 860 F.3d 335 (5th Cir. 2017), a home health provider challenged a Medicare contractor's $700,000 overpayment determination. The contractor arrived at that number after reviewing 40 claims from 22 beneficiaries and concluding that all but one were for cases where patients were not homebound or the services were not medically necessary. The contractor then extrapolated its findings to a universe of 130 claims.

The provider exhausted the administrative review process and the district court affirmed the recovery. On appeal to the U.S. Court of Appeals for the Fifth Circuit, the provider contended, among other things, that: (1) the statistical sampling and extrapolation were not proper because federal regulations call for an individualized claim review for home health services; (2) the sampling was invalid because the contractor failed to adequately document its sampling methodology; and (3) the sampling methodology was invalid because the sampling units were not "independent," due to the use of several claims from the same beneficiaries.

The 5th Circuit found that the extrapolation method was appropriate. In rendering its decision, the court turned to the Medicare Program Integrity Manual and guidance to conclude that an individualized review of claims is not required for post-payment audits and the program language about individualized review is for prepayment review only. Moreover, the court explained that failing to follow the program integrity manual does not render the sampling invalid; rather, the provider must attack the statistical validity of the sample.

With respect to the issue of "independence," the court provided some further insight that may be applicable to health plans that utilize extrapolation. Independence is "important to a proper extrapolation … [because it] means that the (a) probability of denying payments from one sampling unit does not affect (b) the probability of denying the payments to any other sampling unit in the same time frame." The administrative law judge determined that the sampling was invalid because the sampling units were not independent, since multiple claims came from the same beneficiary. The Medicare Appeals Council reversed that determination on the basis that the sampled claims from the same beneficiary were generated in separate time segments and the Medicare Program Integrity Manual contemplates sampling units from clusters such as the same beneficiary.

The 5th Circuit recognized that the provider may have an argument about independence as "understood by statisticians who have developed and articulated the government concepts" — thus overcoming the deference afforded to the Medicare contractor. However, the court explained, the provider did not make this argument.

This case is important to health plans because it offers insights into ways providers can challenge recoupments and overpayment demands based on extrapolation. Special investigation and recovery departments often utilize sampling based on computer programs like RAT-STATS. Unlike the Medicare program, however, health plans will not enjoy deference from courts. Therefore, health plan legal counsel should work with their recovery groups to ensure statistical soundness of evidence when developing sampling methodologies — especially for larger recoveries that are more likely to lead to litigation.

Note that the court repeatedly took issue with the lengthy Medicare appeal process, commenting that Maxmed spent six years litigating the matter and that the Department of Health and Human Services forecasts the number of appeals to rise from 607,402 (as of June 2017) to more than 1 million by the end of 2021.

The court summed up its sentiments: "In Hell there will be due process, and it will be meticulously observed." It might be wise to remember this language from the Fifth Circuit when addressing issues such as Medicare exhaustion in the Medicare Advantage realm, where policy drivers such as this may influence legal decisions.

Section 1332 Waivers on the Rise

By: Stephanie Kennan & Russ Sullivan

While the Senate considered repeal and replace legislation for the Affordable Care Act in July, the Department of Health and Human Services approved its first Section 1332 "State Innovation Waiver," which was submitted by Alaska. With the collapse of congressional efforts, states are moving to stabilize their markets by experimenting with Section 1332 waivers to subsidize healthcare.

When the Trump administration came into office, HHS encouraged states to look at 1332 waivers. Now, Minnesota, Iowa, Oregon, New Hampshire and Oklahoma are applying to provide reinsurance with elements similar to Alaska's waiver. California, Texas, Kentucky, Ohio, Vermont, Massachusetts and Rhode Island are in various stages of applying. Seven other states — Washington, Colorado, New Mexico, Arkansas, Georgia, South Carolina and Maine — are also looking at this option.

What Is a Section 1332 Waiver?

ACA Section 1332 was designed as a mechanism for states to further develop coverage models. The waiver allows states to change some of the requirements of the ACA so long as: (1) coverage remains as comprehensive as it is under the ACA; (2) coverage is at least as affordable as it is under the ACA; (3) coverage is offered to a similar number of state residents as under the ACA; and (4) the waiver does not increase the federal deficit.

How Does Alaska's Section 1332 Waiver Work?

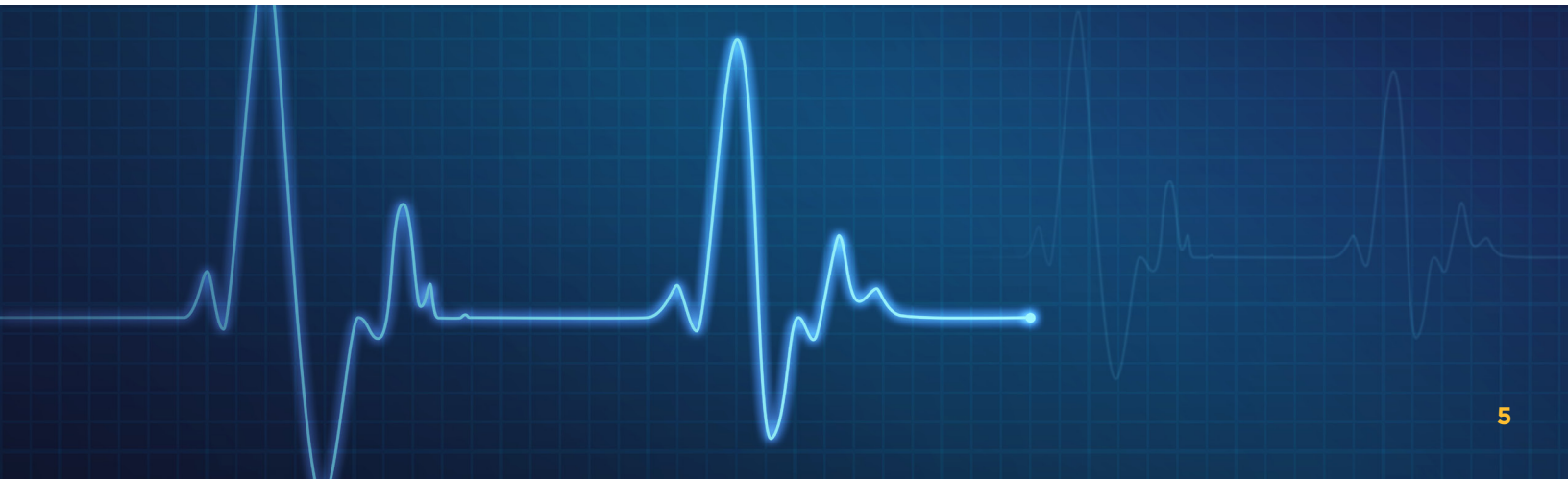
In 2016, Alaska developed a reinsurance program to stabilize its ACA exchange. The state government provided insurers with additional funding to cover the cost of 33 specific diseases anticipated to result in significant medical expenses. As a result, the cost of exchange plans, anticipated to rise by 42 percent, rose instead by only 7 percent.

Under Alaska's Section 1332 waiver, federal funding will now cover a portion of this program's costs. It was estimated that, without this program, insurance premiums would increase by approximately 20 percent in 2018. Federal subsidies, pegged to health insurance premiums, would have risen by a corresponding amount. Instead, the amount the federal government saves on subsidies because of the reinsurance program will be used to fund part of the reinsurance plan, in addition to state funding. A waiver is required under this program because the ACA requires a state to treat all individuals on the exchange as if they were in a single-risk pool. The Alaska waiver allows the reinsurance program to segregate those people with unusually high medical costs.

What Are the Pros and Cons?

To the extent that Section 1332 waivers allow states to take steps to create some stability in the exchanges, everyone will benefit. HHS touted the reinsurance waiver model based on one year of experience in Alaska. Alaska has a small population, which inspires some to question scalability of results to states with larger populations. Using Section 1332 waivers for reinsurance programs will not cure all of the uncertainty in the market, particularly uncertainty around the continuation of cost-sharing reduction payments. Should corporate social responsibility payments stop, states could look to using Section 1332 waivers as a stopgap measure to replace them. However, states have only so much funding available to stabilize the market.

To the extent states are open to significant reforms, Section 1332 waivers create opportunities for strategic decision-making. Healthcare companies located in states receptive to Section 1332 waivers have a unique opportunity to shape the development of waiver applications. Additionally, companies willing to develop innovative models for providing insurance, offering care or selling products, may find unique opportunities to develop or invest in states that use Section 1332 waivers to develop new mechanisms for financing and delivering healthcare.



Oversight, Audits and Enforcement of Medicare Advantage Organizations Likely to Grow

By: Jakarra Jones

Under the current administration, Medicare Advantage organizations (MAOs) should expect increasing government oversight, auditing and enforcement.

Risk adjustment is one large risk area at this time. The Centers for Medicare & Medicaid Services (CMS) estimates that 9.5 percent of risk adjustment payments to MAOs are improper due to unsupported diagnoses. In May 2015, U.S. Sen. Claire McCaskill, D-Mo., raised concerns with CMS of risk score "gaming" in the Medicare Advantage (MA) program.

In an April 17, 2017, letter, U.S. Sen. Chuck Grassley, R-Iowa, asked CMS Administrator Seema Verma to explain why CMS had failed to collect nearly $125 million in potential overcharges identified at five MAOs audited for 2007. He suggested that CMS increase audits due to expected MA growth.

In May 2017, MAO Freedom Health Inc. and its former COO paid $32.5 million to settle charges that they had violated the False Claims Act (FCA) by submitting unsupported diagnosis codes to CMS, resulting in inflated reimbursements in connection with

two of its Florida MA plans. That settlement finalized in the same month as the Department of Justice's (DOJ's) well-publicized intervention in two *qui tam* FCA suits involving one of the largest MA insurers concerning alleged inflated risk adjustment data, which allegedly resulted in inflated payments.

Signaling broader enforcement trends, the per-claim monetary penalty for FCA violations has doubled, pursuant to the Bipartisan Budget Act of 2015 and DOJ's Feb. 3 finalization of its interim final rule setting a minimum per-claim penalty of $10,957 and maximum penalty of $21,916. As in years past, healthcare and life sciences companies continued to dominate FCA enforcement and recoveries in the first half of 2017, and this trend is likely to continue, given Deputy Attorney General Rod Rosenstein's healthcare industry FCA experience as the former U.S. attorney for the District of Maryland.

Managed care organizations would be wise to adopt an aggressive and proactive stance in mitigating the risk of FCA suits. In the healthcare industry, FCA suits are most commonly brought by former employees. Therefore, in addition to having a robust compliance program, conducting substantive exit interviews may help put companies on notice of potential issues.

A Little Help From HIPAA

By: Nathan Kottkamp

The Health Insurance Portability and Accountability Act Security Rule requires that covered entities perform "periodic" security risk assessments. All too often, however, this regulatory obligation is ignored altogether, performed extremely sporadically, or treated as a regulatory hoop-jumping exercise to be completed as quickly as possible. Besides increasing the risk of HIPAA liability, treating the Security Rule risk assessment in this manner means missing an opportunity to explore and shore up the entity's data security systems.

Despite what criticisms may exist for other parts of the HIPAA regulations, the Security Rule can be a remarkably helpful tool. Rolled out in 2013, it has survived the test of time and astonishing changes in technology. One reason for this is that the Security Rule expressly incorporates a "flexibility of approach," making it applicable to covered entities of all sizes and configurations.

At its core, the Security Rule aims to ensure the confidentiality, integrity and availability of electronic protected health information, and the elements of the rule reflect the measures already expected of any responsible organization operating in the digital age.

When performed properly, the Security Rule risk assessment helps entities examine their operations to identify where and how their data is stored, reasonably anticipate and address any risks to their data, and identify the various ways in which they manage their operations with respect to a fairly logical set of required and addressable criteria. This exercise can be critical to helping in-house counsel and the compliance team understand where the organization's information "lives," who is in charge of securing the data, and what areas of potential vulnerability require attention.

Lawyers do not often applaud regulations, but in the case of data security practices, the HIPAA Security Rule can be tremendously helpful, and all entities should take it seriously.

Healthcare Q&A With Dr. Peter Kongstvedt

In the Q&A that follows, McGuireWoods partner Edwin Brooks talks to healthcare industry expert Dr. Peter Kongstvedt on risks that plans and providers face and possible changes to the Affordable Care Act.

Q **What significant risks do health plans and providers currently face and what do you see down the road?**

A **The political environment is the most obvious, though mostly for payers in the individual and small group markets. This risk includes potential elimination of cost-sharing reductions, funding for risk corridors, and reinsurance. Provider and drug-manufacturer market power and pricing increases will only accelerate, to be passed on to customers except when regulators require plans to sustain losses. Perhaps the largest risk is that it is still far easier to assert that payers are making excess profits than it is to step up to the far more complex and widespread reality of managing price increases. This risk is compounded by the uncertainty of federal enforcement of Affordable Care Act (ACA) provisions meant to stabilize the individual and small group markets, resulting in further cost increases or exiting of those markets.**

Q **How do you see health plans and providers dealing with those risks?**

A **In the current environment, payers have little direct political clout — of the $509 million spent on healthcare lobbying, only 2.9 percent was spent by payers — but they do exert pressure by their actions, at least in the individual and small group markets. Right now, that means increases in consumer cost-sharing, increases in premiums as a result of adverse risk, premium increases in the face of uncertainty in federal enforcement meant to offset some risk and stabilize the markets, or exiting those markets altogether.**

Q **What changes to the ACA do you see happening, if any?**

A **The ACA, like all laws, requires changes from time to time. But unlike most laws, the political environment is freezing the ACA as it was originally passed. That leaves only enforcement, which does change. At present, federal payments meant to stabilize the individual and small group markets are on shaky ground, as is enforcement of coverage mandates. I don't see an outright repeal of the ACA any time soon, if ever, but Congress may yet emerge from its current stalemate and work toward addressing the ACA's very real flaws.**

Dr. Peter Kongstvedt is an independent strategic adviser and a senior health policy faculty member in the Department of Health Administration and Policy at George Mason University. He was appointed by Virginia Gov. Terry McAuliffe to serve on Virginia's Board of Medical Assistance Services (Medicaid). He also is a senior adviser to Navigant Consulting Inc. and its clients.

He is a well-known national authority on the health care industry, with particular expertise in health insurance and managed health care, and extensive industry experience as a senior-level executive and a partner with global consulting firms. Dr. Kongstvedt is the primary author and editor of two widely used textbooks: *The Essentials of Managed Health Care*, Sixth Edition (2013), and *Health Insurance and Managed Care, What They Are and How They Work*, Fourth Edition (2015).

Recent Industry Case Developments

- **Provider Networks:** *Medical Diagnostic Laboratories, LLC v. Independence Blue Cross*, 2017 U.S. Dist. LEXIS 140256 (E.D. Penn. Aug. 30, 2017) (Case No. 16-5855) (out-of-network lab sued plan for antitrust violations and state common-law causes of action when plan directed providers to send lab work to in-network provider; court granted motion to dismiss antitrust claims and tortious interference with existing contract, but denied the motion as to tortious interference with prospective contractual relations and state unfair competition claims).
- **Provider Payments:** *American College of Emergency Physicians v. Price*, 2017 U.S. Dist. LEXIS 140314 (D.D.C. Aug. 31, 2017 (Case No. 16-913) (emergency physicians sued CMS for violating the Administrative Procedures Act with respect to the final rule on out-of-network emergency services payments — i.e., the greater of three (GOT) rule; court found that CMS acted arbitrarily in failing to properly respond to comments in rule-making and remanded the matter to the agency for proper consideration of comments on the GOT rule, including use of FAIR Health).
- **Member Benefits:** *Strauss v. Premera Blue Cross*, 2017 Wash App. LEXIS 2086 (Ct. App. Wash. Sept. 5, 2017) (appellate court affirmed summary judgment for plan on member claims for breach of contract, denial of coverage in bad faith, and violation of consumer laws relating to denial of coverage of proton beam therapy; court found that the treatment was not covered under the terms of the benefit plan).
- **Arbitration:** *Managed Health Care Administration v. Blue Cross and Blue Shield of Alabama*, 2017 Ala LEXIS 82 (Ala. Sept. 1, 2017) (Alabama Supreme Court reversed lower court decision finding that the health plan was not subject to an arbitration clause; court determined that the issue of arbitrability was for the arbitrator to decide because it incorporated the AAA Commercial Arbitration rules, which gives the arbitrator authority to determine issues of jurisdiction including whether the plan is subject to the arbitration clause).

Upcoming Events

Healthcare Litigation and Compliance Webinar CLE Series

Effective Internal Investigations for Healthcare Entities

September 19, 2017

Registration now available >>

Bringing and Defending Overpayment Recoveries – A View from Both Sides

October 19, 2017

Registration now available >>

7 Elements of an Effective Compliance Plan and Mitigating Compliance Risk

November 13, 2017

Registration forthcoming

The Future of False Claims Litigation Against Providers and Payors

December 7, 2017

Registration forthcoming

Healthcare Litigation and Compliance Conference

May 30, 2018 | Four Seasons, Chicago

Contributor Spotlight

MICHAEL ADAMS
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Michael is a partner in McGuireWoods' Charlotte office who focuses on data privacy, cybersecurity and technology issues. Mike served more than 20 years as a national security advisor in the U.S. Navy, most recently serving as deputy general counsel to the Chairman of the Joint Chiefs of Staff. During his three-year tenure with the Chairman of the Joint Chiefs, he counseled the country's top military officers, civilian advisors and Congress on cybersecurity, privacy, information governance and technology.

CATHY HESS
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Cathy is a senior counsel in McGuireWoods' Washington, D.C., office who has nearly two decades of private practice, federal government and in-house experience in healthcare fraud and abuse investigations and compliance. Cathy represents healthcare clients in criminal, civil and administrative government enforcement matters.

From 2007 to 2013, Cathy served in several roles at the HHS-OIG, including acting Deputy Chief and Senior Counsel in the Administrative and Civil Remedies Branch of the Office of Counsel, as well as a detail appointment as the Special Assistant to the Principal Deputy. In her role as Senior Counsel, she oversaw a diverse and complex portfolio of False Claims Act and Civil Monetary Penalty Law cases, including conducting investigations and negotiating settlements and corporate integrity agreements.

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