ORANGE COUNTY BAR ASSOCIATION

HEALTH CARE LAW SECTION WEBINAR

Managed Care Litigation

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Managed Care Litigation

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What is “Managed Care”?

- Managed care is a risk-based system in which the *medical providers* take risk.
- It can be contrasted from pure indemnity insurance in which the insurer accepts all of the risk.

How Do Providers Accept Risk?

- "Capitation" is the most common form.
- A healthcare provider is paid a flat monthly fee per patient in exchange for providing those patients healthcare services.

Upside and Downside Risk

- **Upside**: The healthier the patients, the fewer services must be rendered, and the more profitable the providers can become.

- **Downside**: The sicker the patients, the more services must be rendered, leading to lower profits or losses.

Types of Parties in Litigation

- **Payors**: the entity paying for the medical services, *e.g.*, the insurer, independent practice associations, hospitals
- **Healthcare Providers**: hospitals, medical groups, doctors, ancillary service providers
- **Patient-Members**: the individual consumer

Interests of the Parties

- **Payors**: pay what is owed under the plan but not beyond the contracted risk as assumed by the plan's actuaries
- **Providers**: keep patients healthy and obtain fair compensation for the services rendered
- **Patient-Member**: obtain the medical care needed at the lowest out-of-pocket cost

Types of Managed Care Plans

- **Health Maintenance Organization (HMO)**
  - Primary Doctors act as "Gatekeepers" for Specialty Services
  - Mandatory In-Network Provider Use

- **Preferred Provider Organization (PPO)**
  - Financial Incentive for In-Network Use
  - Deductibles

Types of Managed Care Plans

- **Point of Service Organization (POS)**
  - Combination of the full suite of providers in an HMO and out-of-network options of a PPO
- **Exclusive Provider Organization (EPO)**
  - No out-of-network options

California Reimbursement Claim Timeline

1. Provider renders a service
2. Provider submits a timely claim within 90 to 180 days. 28 C.C.R. § 1300.71(b)(1)
3. Acknowledgement of receipt of claim within 2 to 15 working days. 28 C.C.R. § 1300.71(c). Can be through website portals.
4. Reimbursement or denial within 30-45 working days of receipt of a "complete" claim. 28 C.C.R. § 1300.71(g)-(h)
5. Late payment of claims requires automatic interest at 15% per annum. 28 C.C.R. § 1300.71(i)
6. Requests for additional information if the plan contests that the claim is not a "complete claim" with all information necessary to determine the payor's liability. 28 C.C.R. § 1300.71(a)(2)

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Common Subjects of Litigation

- Out-of-Network Reimbursement Litigation
  - Emergencies
  - Network Gaps
  - Overpayment Recoveries
- In-Network Arbitration
  - Characterization of Services with Different Contract Rates
  - Coverage Disputes
  - Overpayment Recoveries
- ERISA Plans – Employee-Sponsored Plans
- Medicare Administrative Proceedings

Coding of Claims

- Claims forms require use of coding systems to identify types of services rendered. *E.g.*, Current Procedure Terminology (CPT).

- *YDM Management v. Sharp Community Medical Group* (2017) 16 Cal.App.5th 613 – use of incorrect codes may reduce or eliminate a payor's liability.

- *San Jose Neurospine v. Aetna Health of California* (2020) 45 Cal.App.5th 953 – medical records or testimony can supplement the record to overcome coding errors

Provider Causes of Action for Reimbursement

1. Breach of Contract – Written, Oral
2. Breach of Contract – Implied
3. Breach of Contract – Third Party Beneficiary
4. Quantum Meruit
5. Intentional Misrepresentation, Promissory Fraud, Negligent Misrepresentation
6. Unfair Business Practices (Bus. & Prof. 17200)
7. Statutory Liability, *e.g.*, Civ. Code 3428(a), 28 C.C.R. § 1300.71.
8. Indebitatus Assumpsit – blend of quantum meruit and breach of contract
   - *Higgins v. Desert Braemar, Inc.* (1963) 219 Cal.App.2d 744 (1963)

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Payor Causes of Action for Overpayment

- Breach of Contract
- Unjust Enrichment
- Fraud
  - Upcoding
  - Co-payment, coinsurance, or deductible waiver theories. *E.g.*, *Davidowitz v. Delta Dental Plan of California, Inc.* (9th Cir. 1991) 946 F.2d 1476, 1479.

In-Network Litigation: Reasons for Denial of Claims

- Benefits exclusions within policy
- Provider is not within network
- Failure to obtain pre-approval, if required
- The services were not medically necessary or were "experimental"
- The patient is not a member or ineligible (*e.g.*, failure to pay premiums, fraud in application)
- Untimely claim submissions
- Substandard care or unlicensed provider

In-Network Litigation: "Silent" PPOs

- Provider → Third Party Network / Contracting Agent → Health Plan
- Health plans "access" the third party network to obtain contracted reimbursement rates, oftentimes set as a percentage of billed charges (*e.g.*, 85%, 90%)
- The Healthcare Providers' Bill of Rights (Health & Safety Code, § 1375.7(d)(1)) – provider's contract preempts the contracting agent's agreement with the health plan.
  - Includes other rights and obligations of health plans.
- May entitle the Provider to higher payments as a "contracted provider with a written contract." 28 C.C.R § 1300.71(a)(3)(A)

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Out-of-Network Litigation: Emergencies

- Section 1317 of the Health & Safety Code requires health facilities with emergency departments to treat patients with emergency conditions and forbids discriminating against patients by virtue of their insured or uninsured status.

- The Emergency Medical Treatment & Labor Act (42 U.S.C. § 1395dd) or "EMTALA" requires Medicare-participating hospitals to "stabilize" patients with emergency medical conditions. *See also* 10 C.C.R. § 2240.1(b)(6), (e).

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Out-of-Network Litigation: Emergencies

- Out-of-network medical providers can recover reimbursement for emergency services against payors.
  - Doctor vs. Health Plan: *Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211.
  - Medical Group vs. Medical Group: *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group* (2009) 45 Cal.4th 497.
  - Title 28, California Code of Regulations, section 1300.71(a)(3)(B).

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Out-of-Network Litigation: Emergencies

- "Reimbursement of Claim" is the "reasonable and customary value" under 28 C.C.R. § 1300.71(a)(3)(B).

- The *Gould* factors is a six-factor test enumerated by *Gould v. Workers' Comp. Appeals Board* (1992) 4 Cal.App.4th 1059, 1071:
  1. Medical provider's training, qualifications, and length of time in practice
  2. Nature of services provided
  3. Fees usually charged by the provider
  4. Fees usual charged in the general geographic area
  5. Other aspects of the economics of the medical provider's practice that are relevant
  6. Any unusual circumstances of the case.

Out-of-Network Litigation: Network Gaps and Authorizations

- Health plans have an obligation to arrange for medically appropriate care for all members, no matter how difficult the care is! 10 C.C.R. § 2240.1(b)(6), (e).

- Reimbursement rate could be the provider's billed charges, the "reasonable and customary" amount, or the "amount set forth in the enrollee's Evidence of Coverage." 28 C.C.R. § 1300.71(a)(3)

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Out-of-Network Litigation: Network Gaps and Authorizations

- 28 C.C.R. § 1300.71(a)(3): "Reimbursement of a Claim" means:
  - (A) **For contracted providers with a written contract**, including in-network point-of-service (POS) and preferred provider organizations (PPO): the agreed upon contract rate;
  - (B) **For contracted providers without a written contract and non-contracted providers, except those providing services described in paragraph (C) below**: the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration: (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case; and
  - (C) **For non-emergency services provided by non-contracted providers to PPO and POS enrollees**: the amount set forth in the enrollee's Evidence of Coverage.

Out-of-Network Litigation Network Gaps and Authorizations

- If the plan requests the provider to render services, the satisfaction of the request constitutes a benefit for purposes of quantum meruit. *Earhart v. William Low Company* (1979) 25 Cal.3d 503.

- An "authorization" can constitute a request for services for purposes of quantum meruit. *Regents v. Principal Financial Group* (N.D. Cal. 2006) 412 F.Supp.2d 1037; *Barlow Respiratory Hosp. v. Carefirst of Maryland, Inc.* (C.D. Cal. 2014) 2014 WL 12573394.

Out-of-Network Litigation
Network Gaps and Authorizations

- Alternative theory: A referral from an in-network provider may constitute a "request" by an actual or ostensible agent.

- Alternative Theory: A "Verification of Coverage" is not necessarily a "request." *See, e.g., Barlow Respiratory Hosp. v. Carefirst of Maryland, Inc.* (C.D. Cal. 2014) 2014 WL 12573394, *3.

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Common Defenses by Payors

- Statute of Limitations
  - The statute runs from the "unequivocal denial of payment in writing" or EOB. *Vishva Dev, M.D., Inc. v. Blue Shield of California Life & Health Ins. Co.* (2016) 2 Cal.App.5th 1218

- Failure to Exhaust Administrative Remedies (*e.g.*, dispute mechanisms, appeal rights)

- Unclean hands

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Potential Evidence

- Plan Documents
- Summaries of Plan Benefits, Brochures
- Membership Card
- Provider Agreements (Plan-Provider)
- Conditions of Admission or Provider-Patient Agreements
- Medical Records
- Claim Forms (*e.g.*, UB-04)
- Authorizations
- Verifications of Coverage
- Evidence of Benefits (EOB)
- Evidence of Coverage (EOC)
- Testimony from the treating or referring provider, the provider's administrative personnel in contact with a payor, a plan's representatives, and the patient.

Other Litigation or Proceedings: ERISA Claims and Preemption

- ERISA preemption under 29 USC § 1144(a) for employer-sponsored health plans.
  - A claim which could have been brought under ERISA section 502(a)(1)(B) is preempted. *Aetna Health Inc. v. Davila* (2004) 542 U.S. 200.
  - Most healthcare provider claims are not preempted because the claims could not have been under Section 502(a)(1)(B). *See Blue Cross of California v. Anesthesia Care Associates Medical Group, Inc.* (9th Cir. 1999) 187 F.3d 1045.
  - Provider claims based on assignments of benefits, however, are preempted. *The Meadows v. Employers Health Ins.* (9th Cir. 1995) 47 F.3d 1006, 1008.
- ERISA remedies are limited to plan benefits and "other appropriate equitable relief." Compensatory and punitive damages are unavailable.

Other Litigation or Proceedings: Medicare and Medicare Advantage

- Medicare preemption of state statutes through 42 U.S.C. § 1395w-26(b)(1).

- Preemption applies to Medicare and Medicare Advantage plans.

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Other Litigation or Proceedings: Omnibus Claim Cases

- A single proceeding instituted to collect on numerous reimbursement claims

- Statistical Sampling?
  - Held permissible: *Maxmed Healthcare, Inc. v. Burwell* (W.D. Tex. 2016); *Braggs v. Dunn* (M.D. Ala. 2016) 317 F.R.D. 634
  - Held impermissible: *U.S. v. Vista Hospice Care, Inc.*, No. 3:07-cv-00604-M (N.D. Tex. June 20, 2016) (determination "inherently subjective, patient-specific, and dependent on judgment" of physicians)

Other Litigation or Proceedings

- Antitrust
- HIPAA or state law privacy breaches
  - Private Right of Action under the Confidentiality of Medical Records Act (Civ. Code 56.35)
- Fair Hearing Rights Cases after Provider Excluded from Network
- False Claims Act cases
- Network Adequacy cases
  - Misrepresentations that providers were in-network
  - Allegations that network insufficient

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