KING & SPALDING

Medicare Advantage Plans: Issues and Litigation

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PRESENTED BY

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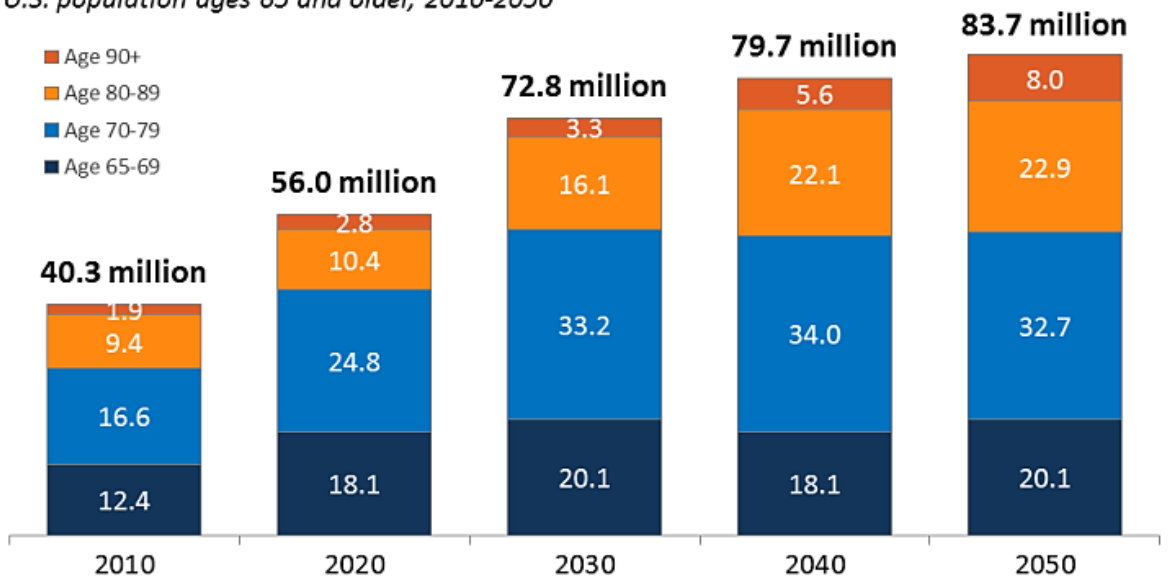
A2HA Spring 2019 Meeting

Demographics Tell the Story

The aging of the population and rising health care costs are contributing to the growth in Medicare spending over time

U.S. population ages 65 and older, 2010-2050



SOURCE: Kaiser Family Foundation analysis of 2010 population estimates from U.S. Census Bureau. Population Division. Vintage 2011: National Tables. Table 1. Annual Estimates of the Resident Population by Sex and Five-Year Age Group for the United States: April 1, 2010 to July 1, 2011 (NC-EST2011-01), May 2012; and 2020-2050 population projections from U.S. Census Bureau, Population Division. 2012 National Population Projections: Summary Tables. Projections of the Population by Age and Sex for the United States: 2015 to 2060 (NP2012-T12); December 2012.

Medicare benefit payments expected to increase from $702 billion in 2017 (17% of federal budget) to $1.2 trill. in 2027

The Growing Importance of Medicare Advantage

Meanwhile Medicare Advantage payments accounted for 30 percent of all Medicare payments in 2017 ($210 billion)

- Up from 18 percent in 2007

Over 50% of new Medicare enrollees choose a Medicare Advantage Plan.

As of 2018, 35% of all Medicare enrollees are MA enrollees

Medicare Advantage is projected to have 50% of all enrollees by 2025, and could have 70% by 2030-40.

“The hospital prices paid by MA plans are nearly identical, on average, to Medicare FFS prices but much lower than commercial prices.”

- June 2017 CBO Analysis

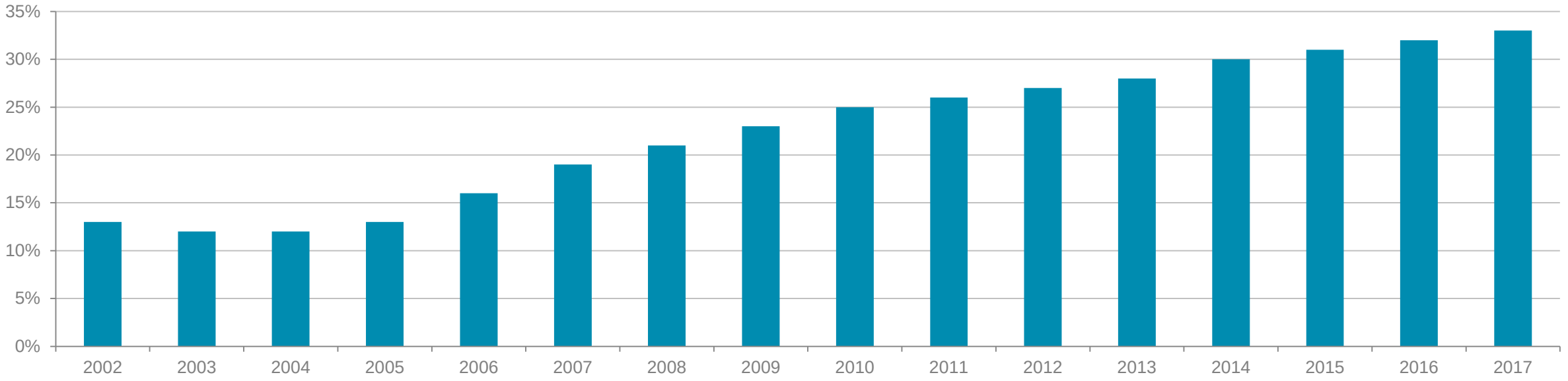
SOURCES: 2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicare Insurance Trust Funds
Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds /Downloads/TR2018.pdf

Agenda

- Overview of Growth of Medicare Advantage (MA)
- Contracts with MA Payers – Tactics and Responses
- Appeals
- Litigation

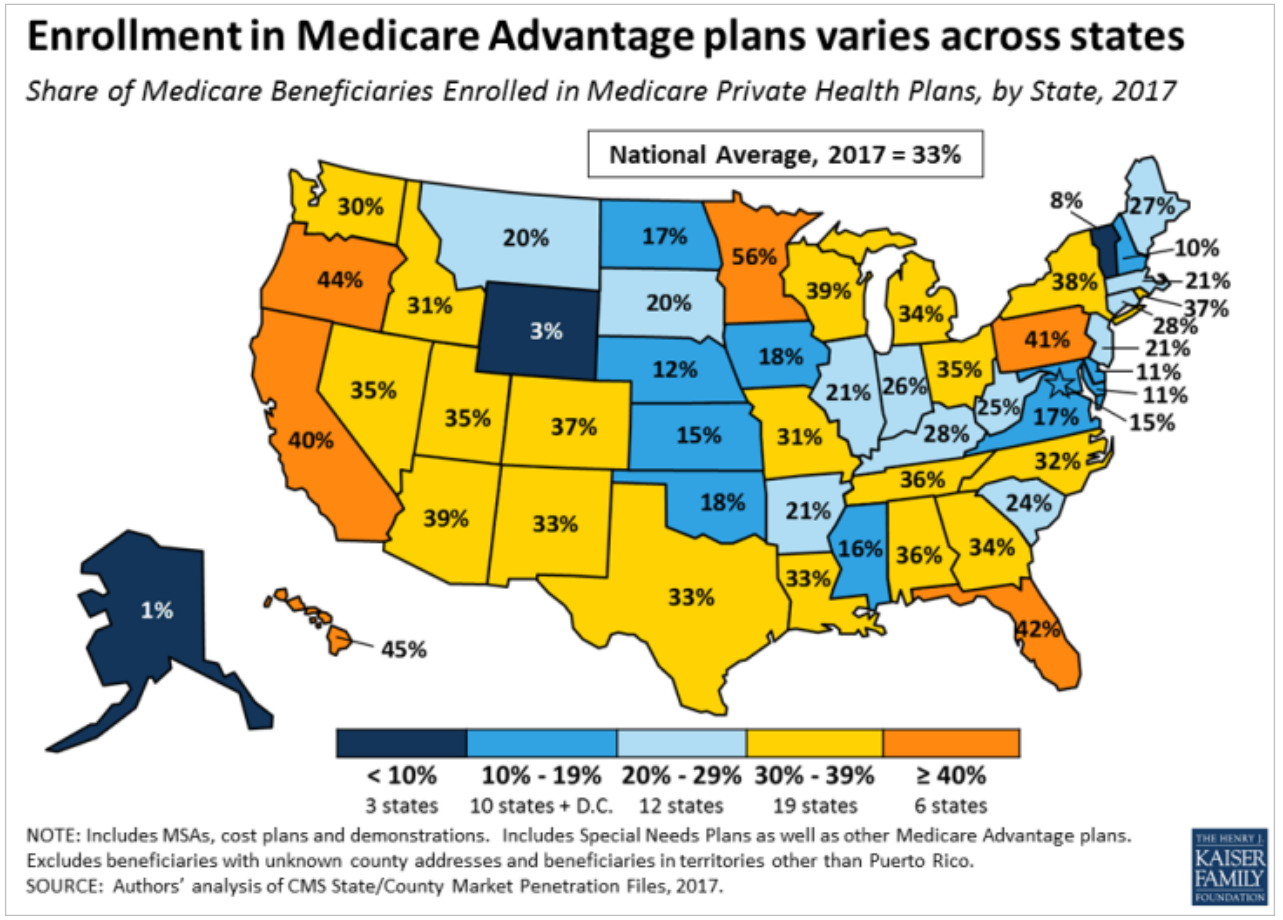
The Growing Importance of Medicare Advantage (cont'd)

Medicare Advantage Enrollees as a Percent of Total Medicare Population



SOURCE: https://www.kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population/?currentTimeframe=15&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

The Growing Importance of Medicare Advantage (cont'd)



Medicare Advantage Contracting

Do you even want a contract?

- Facility Perspectives
- Physician Perspectives

Practical aspects of serving MA beneficiaries with no provider contract.

- Provider must accept Medicare Allowed amount as payment in full.
- Provider will not receive steerage from HMO members, and limited steerage from PPO.
- Difficulties enforcing payment obligations.

Bargaining Power and Terminations

Payers seek to dictate all the terms of a managed care agreement.

When providers lack sufficient bargaining power to resist this, the payers succeed.

There are many reasons to dread any contract termination.

For some providers, some contract terminations can be tolerated.

MA Payer Negotiation Tactics

Payers may **open up numerous language issues** by demanding that new “templates” be used, to introduce traps into the contract and to create bargaining chips to be traded for lower rates.

Payers may **fail to make reasonable offers** or responses, and then suggest strategic extension of existing agreements at existing rates. Payer negotiators with deadlines in August, for example, may seek contract extensions extending to the end of December – to pick up subsequent year "lives," improve leverage and make member plan switching more difficult. The new open enrollment period from January – March during which members may switch between MA plans may effect these tactics.

Some payers may **create a wall between rates and language**, treating them as two entirely separate negotiations. Providers may then be induced to agree to rates without knowing about “required” adverse language that will reduce the value of the contract and introduce risks.

Payers may try to **engineer terminations or contract expirations** in a way that will permit them to blame the provider for the termination.

Payers in terminations may intentionally try to make the situation in the early days **chaotic for physicians and patients**.

(If the provider gives up early, the payer may believe it will avoid the period later into the termination when pressures will arise from employers and government on the payer.)

Medicare Advantage payers in terminations **may allege** that provider communications to beneficiaries regarding available alternative MA payers violate CMS marketing regulations and manual provisions.

Medicare Advantage payers may seek to have all changes in requirements of CMS, including changes that do not have the force of law, **automatically become binding** on the provider until the end of the contract term regardless of the magnitude of the adverse impact.

Medicare Advantage payers may attempt to pass through to contracted providers **payment reductions** impacting them and made by CMS, even if agreements with the providers do not support this action.

Payers may **require compliance** with a “provider manual” that is incorporated into the agreement, but then give themselves the ability to unilaterally amend the manual without the provider’s consent.

In some cases, payer may give themselves the ability to unilaterally amend the agreement, and the provider’s only remedy if it disagrees with the amendment is to terminate the agreement.

Payers may **make coverage changes** that are adverse to provider interests in policies that payers unilaterally issue as purported clarification of medical necessity definitions.

Payers may **give themselves the unilateral right** to designate when a provider is in-network for a particular product, without giving the provider the option to choose whether or not to participate.

Payers may **assert rights**, during the term of provider contracts, to pick certain provider services of in-network providers to be “carved out” to be exclusively or primarily provided by other providers.

In the case of self-insured plans and affiliates that are not direct parties to the contract, attempts may be made to take advantage of agreed rates without complying with other contractual requirements. Out of area Blues plans may attempt to take advantage of rates but apply their own local UM and other policies that are unauthorized and/or in conflict with the provider's agreement.

Medicare Advantage payers may use **template contract attachments** referring to Medicare Advantage that include additional terms that are adverse to providers, while stating or implying incorrectly that such additional terms are required by CMS.

Appeals & Denials

Appeals & Denials

Contracted Provider Appeal Process

Provider appeal rights based on contract with MA Plan and regulations set forth minimum standards.

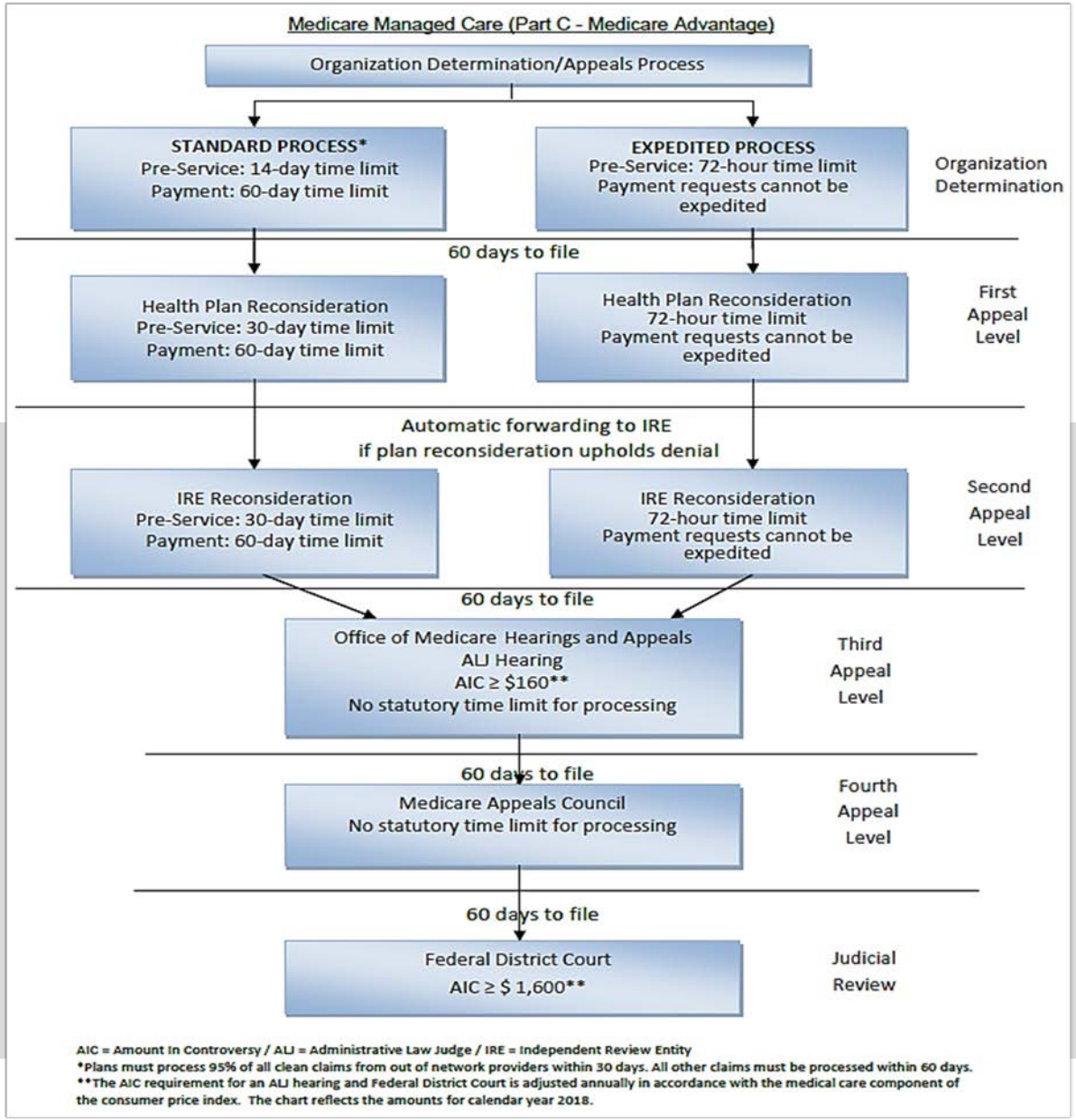
- Typically set forth in Provider Manual
- May include separate processes for “administrative” and “medical necessity” denials (can lead to disputes over classification)

Appeals & Denials

Non-Contracted Provider Appeal Process

Provider may seek review of MA Plan "organization determination" by submitting *waiver of liability* form (which provides that the non-contract provider will not bill the enrollee regardless of the outcome of the appeal) and MA Plan submits the appeal to IRE for review.

See: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index.html



Source: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Managed-Care-Appeals-Flow-Chart-.pdf

Appeals & Denials

Contracted & Non-contracted

Do you have a written policy for handling appeals?

- Timing Requirements — Submission and Follow-up
- Use templates?

Do you have different denial issues with different MA Plans?

Appeals & Denials

Contracted & Non-contracted

Handling medical necessity denials

- Denied Days
- Level of Care Downgrades
- Experimental/Investigational

Handling administrative denials

- Timely filing
- Lack of preauthorization

CMS's Role in Enforcing Medicare Advantage Requirements and Handling Provider Grievances

CMS' Role Generally

CMS's role in:

- Enforcing MA requirements
- Addressing provider grievances against contracted MA plans

→ *Very little.*

CMS Grievance Process

- Regulations concerning grievances against MAOs and related procedures apply specifically, and exclusively, to MA plan enrollees.

CMS' Role in Enforcing MA Requirements

- Non-contracted providers unhappy with an MAO's payment dispute resolution process who have still not been reimbursed fairly after exhausting the internal process may file a complaint with CMS at 1-800-MEDICARE
- CMS account managers have been instructed to closely monitor MAO's actions and may take compliance action

CMS' Role in Enforcing MA Requirements

- CMS recently adopted a triennial review process for network adequacy
- MAOs that fail to meet network adequacy requirements may be subject to compliance or enforcement actions

Litigation

Strategies for Challenging Unsatisfactory MA Plan Behavior

- Face to face meet and confer
- Dispute resolution process/arbitration/litigation
- Reach out to MAC and/or CMS
- Marketplace/contract responses

What to Expect in Litigation with an MA plan

- Typical insurer playbook
  - Delays
  - Obstruction of discovery
  - Threats re: coding violations
  - Manipulation of “settlement discussion privilege”
  - No meaningful offer until eve of arbitration/trial.

What to Expect in Litigation with an MA plan

Payers may try to withhold payments during disputes, and then delay the dispute resolution process as much as possible.

What to Expect in Litigation with an MA plan

Payers may assert that claims cannot be consolidated in order to make dispute resolution more costly and inefficient.

What to Expect in Litigation with an MA plan

Payers may seek to create litigation delay by insistence on minute observation of multi-step dispute resolution processes.

What to Expect in Litigation with an MA plan

Payers may seek confidential arbitrations instead of litigation in open court proceedings accessible to the news media.

What to Expect in Litigation with an MA plan

Payers may seek to create disputes over document retention and production in order to make the provider look like it is hiding something.

What to Expect in Litigation with an MA plan

Payers may use overly broad requests for clinical information or unwarranted audits in order to hold up claims payments, or to institute payment recoupments, in order to gain leverage in unrelated payment disputes.

What to Expect in Litigation with an MA plan

Payers may settle cases at the latest possible moment in order to run up provider litigation expenses, and deter other providers from litigating.

Pros and cons of binding arbitration over litigation

Factors include:

- Public versus private (not publicly filed)
- Experience/quality of decision maker
- Arbitration means no pressure from jury trial (and arbitrators tend to be more even-handed to insurers)
- Length of time to resolve matter

Questions?

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