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California State Court Finds Statute of Limitations for Filing Legal Action Runs from the Date the Plan First Issued an Explanation of Benefits Underpaying the Claim, Not After the Voluntary Appeal Process

By Vinay Kohli

A recent California Court of Appeal decision addressing the statute of limitations created a potential pitfall for health care providers who rely on a plan's voluntary internal appeals process for underpaid claims as a basis to delay filing formal legal action. *See Vishva Dev, M.D., Inc. v. Blue Shield of California Life & Health Insurance Company, Case No. BC270094* (Filed 8-31-16). In this case, the Court of Appeal held that the statute of limitations for an out-of-network medical provider's cause of action against Blue Shield expired while the provider was still navigating the plan's internal appeals process. In sum, the Court found that the provider had waited too long to file his lawsuit after the plan underpaid and thus lost the right to pursue formal legal recourse after the internal appeal process failed to yield the requested payments. As a result, providers who wait to file a lawsuit until having gone through a health plan's voluntary appeal process may be out of luck.

Like many provider-health plan disputes, this case arose from the alleged underpayment of medical claims. In this case, the provider was a cardiologist, who provided emergency medical care to three patients insured by Blue Shield, and timely submitted his bills to their insurer. Blue Shield responded by paying less than 15 percent of billed charges. In the Explanation of Benefits (EOB) for the payment, Blue Shield offered to consider additional information, and invited the provider to appeal, stating: "If you have questions about your claim or your claim has been denied and you believe that additional information will affect the processing of your claim, you should contact [the] Customer Service Department...If you are not satisfied with [its] response to your inquiry, you may initiate an appeal in writing." The provider submitted additional information with multiple appeals to Blue Shield for all three patients. Blue Shield responded with a small increased payment for one patient that was still significantly lower than the amount billed, and no increase on the other two patients.

The provider asserted an implied contract cause of action in state court to recover the reasonable

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value of his services. He filed his lawsuit less than two years after the provider had completed the internal appeals process, but more than two years after he had received the Blue Shield EOBs. Blue Shield raised a statute of limitations defense on the grounds that the provider's claims are governed by a two-year statute of limitations. The provider responded that the statute of limitations had not commenced until he had exhausted the appeals process. The provider also argued—in the alternative— that Blue Shield should not be allowed to invoke the statute of limitations defense because Blue Shield induced him to delay filing litigation by stating in the EOB that the provider could submit additional information to get reconsideration.

The trial court sided with Blue Shield. The Court of Appeal agreed. Recognizing that it could find no California case law in the health care context that addressed the effects of a voluntary internal appeal process on the statute of limitations, the Court of Appeal looked to cases in the home insurance context for guidance. It compared the denial letters that insurers sent to homeowners with the EOBs that Blue Shield sent to the provider, and found both used near-identical language when denying a claim. Since the homeowner insurance cases had found this language triggered the statute of limitation, the Court of Appeal here found that Blue Shield's EOBs constituted an "unequivocal" denial of benefits that was sufficient to trigger the statute of limitations against the provider.

The Court of Appeal also was unpersuaded by the provider's alternative argument that Blue Shield's denial had not become unequivocal while the plan's voluntary, internal appeals process was occurring. It found that Blue Shield's offer in the EOBs to consider additional information did not render its denial unequivocal so as to toll the statute of limitations during the internal appeal process.

The full extent to which this new case will apply to other claims dispute situations between providers and health plans is unclear. There can be a variety of specific facts that may allow a party to toll the statute of limitations, such as, for example, the communications between the plan and provider before, during, and after using an appeals process, the specific nature of the appeal process offered by the plan, the conduct of the health plan and the provider, the specific type of health care coverage, the plan's specific policies, procedures and plan documents, etc. The outcome may also depend on the legal theories that are advanced, the laws that apply, and the authorities that are presented to the particular court considering the issue.

However, this case should serve as a reminder to providers who are underpaid to consider the statute of limitations when deciding how long to wait for a plan's internal appeal process to yield the requested outcome. The easiest way to avoid the statute of limitations — and the potential for additional legal expenses associated with litigating the issue — is to act sooner rather than later at every step. In light of this case, providers who put off filing litigation are more likely to spend time and money addressing issues that relate to the timing — as opposed to the merits – of their legal proceeding than providers who act sooner after claims are partially or entirely denied.

We have successfully represented many types of providers over the years in addressing these and other time-based defenses raised by health plans. For additional information, please contact Glenn Solomon or Vinay Kohli in Los Angeles at 310.551.8111, or Jennifer Hansen in San Diego at 619.744.7310.

New Exception to the Corporate Practice Ban for Critical Access Hospitals

On September 23, 2016, Governor Jerry Brown signed into law AB 2024, which includes a new exception to California's ban on the corporate practice of medicine for critical access hospitals.

This new exception, which amends California Business and Professions Code Section 2401, would permit federally certified critical access hospitals to *directly employ* physicians and bill for their services so long as:

(1) The hospital's medical staff concur by affirmative vote that the employment is in the best interest of the communities served by the hospital; and

(2) The hospital does not interfere with, control, or otherwise direct a physician's professional judgment in a manner prohibited by Section 2400 or any other law.

The new law, which has been described as an attempt to help hospitals address physician shortages in rural areas, is scheduled to sunset at the end of 2023. In order to be certified as critical access, a hospital must have no more than 25 inpatient beds, must offer 24-hour, 7-day-a-week emergency care, must be located in a rural area and typically must be at least a 35 mile drive away from any other hospital (among other requirements).

The bill goes into effect January 1, 2017.

HLB attorneys routinely advise hospitals with respect to physician relationships. For more information, contact Ben Durie in San Francisco at 415.875.8502.

Prepare for Medi-Cal EHR Audits: OIG Finds $22 Million Overpayments to 95% of Audited Hospitals; DHCS Promises to Audit All Hospital EHR Payments

By Felicia Y Sze

On September 29, 2016, the Office of Inspector General for the U.S. Department of Health and Human Services (OIG) published findings of its audit of Medi-Cal Electronic Health Record (EHR) payments made to 64 hospitals from October 1, 2011, through December 31, 2014. These hospitals received 53 percent of Medi-Cal EHR incentive payments from the State of California to eligible hospitals during this time period. Altogether, the State paid 263 hospitals approximately $601 million during this time period. The OIG report found overpayments and some underpayments to 61 of the 64 hospitals, which net to $22 million. The OIG also noted that prospective payments to these hospitals should be reduced by an additional $6.3 million.

The OIG recommended that the DHCS refund this $22 million to the federal government, adjust prospective payments to these hospitals, and audit all hospitals to ensure the accuracy of their Medi-Cal EHR incentive payments. While the DHCS disputed the calculation of the overpayments to hospitals, it agreed to audit the Medi-Cal EHR incentive payments made to all 263 hospitals to date. Earlier this summer, the DHCS temporarily suspended all hospital attestation reviews and payments until the OIG final report was received and analyzed by the DHCS.

The OIG determined that the calculation of EHR incentive payments were erroneous because they included:

- unpaid Medicaid bed-days in the Medicaid-bed-days-only portion of the Medicaid share (30 hospitals);
- non-acute-care services (23 hospitals);
- hospital data not supported by documentation required to be retained (21 hospitals);
- bad debt within charity-care charges (13 hospitals);
- Medicaid dual-eligible acute inpatient bed-days in the numerator (5 hospitals); and
- clerical errors, such as reporting an incorrect charity-care charge because of a keying error (5 hospitals).

In addition, the OIG found that the incentive payment calculations did not include the following services that it contended should have been included:

- labor and delivery services (12 hospitals),
- NICU services (10 hospitals), and
- intensive-care services (8 hospitals).

These issues have been confusing for many hospitals, which followed instructions from the DHCS to use specific data from cost reports for the attestation. As noted by the OIG, the DHCS did not follow more specific guidance from CMS in instructing hospitals how to enter data from cost reports, i.e., to remove certain data elements. In turn, many hospitals relied on the instructions from DHCS in estimating the amount of expected payment amounts.

Notably, the OIG did not recommend that the State recoup Medi-Cal EHR incentive payments already paid to hospitals. At this point, it is unclear whether the State intends to do so. However, the State's agreement to audit all Medi-Cal EHR incentive payments to hospitals strongly suggests that the State intends to recoup funds according to the methodology expressed by the OIG. A key question is how the DHCS can take back money when the hospitals were relying on the DHCS' own instructions, as approved by CMS.

Hooper, Lundy & Bookman, P.C. has represented hospitals with respect to the OIG audit, as well as other Medi-Cal EHR audits. For more information, please contact Felicia Sze in San Francisco at 417.875.8503, or Lloyd Bookman in Los Angeles at 310.551.8185.

Three New Rounds of Residency Slot Redistribution; Applications Due Soon

By David J. Vernon

On August 2, 2016, the Centers for Medicare & Medicaid Services (CMS) issued its Hospital Inpatient Prospective Payment Systems (IPPS) final rule for Federal Fiscal Year 2017 (Final Rule). Contained within the Final Rule was a notice from CMS of the closure of three teaching hospitals and the opportunity for hospitals to apply for the newly available graduate medical education resident slots under Section 5506 of the Affordable Care Act (ACA).

Background and Balanced Budget Act of 1997

In 1997, in an effort to limit the cost of health care, in part related to the cost of training physicians, Congress passed the Balanced Budget Act of 1997 (BBA '97). BBA '97 instituted a cap on the number of allopathic and osteopathic residents for which Medicare would provide reimbursement. The cap limits the number of full-time equivalent (FTE) residents to those training at a hospital in 1996. The cap is difficult to grow; although there are certain exceptions. Still, the residency cap has significantly impacted direct graduate medical education (DGME) and indirect medical education (IME) reimbursement to teaching hospitals and academic medical centers in the United States.

Affordable Care Act Changes to Residency Slot Redistribution

Despite the residency cap, in the years following BBA '97, teaching hospitals continued to grow residency programs and training opportunities to fill community needs. But due to the cap, unless fitting in an exception, the cost of training these residents was not reimbursed by Medicare. As a result, teaching hospitals sought ways to capture additional residency slots to expand their residency cap.

With the enactment of the ACA, two ways in which a cap could be increased included (1) capturing slots not being used within the cap of another teaching hospital, or (2) capturing slots from a closing teaching hospital that were otherwise "lost." The ACA addressed these two situations under Sections 5503 and 5506. Under Section 5503 of the ACA, 42 U.S.C. § 1395ww(d)(5)(B)(v) was amended and subsection (h)(8) was added to provide for the reduction in FTE resident caps for IME and DGME, respectively, for certain hospitals training fewer residents than their caps allowed and to authorize the redistribution of those slots to other qualified hospitals.

Section 5506 of the ACA added new clause (vi) to 42 U.S.C. § 1395ww(h)(4)(H), instructing the Secretary to establish a process by regulation to redistribute residency slots after a teaching hospital closes. This process established a way for the Secretary to permanently increase the FTE resident caps for certain hospitals, so that the closed hospitals' resident slots would no longer be "lost." By statute, the process for distributing the residency slots prioritizes hospitals in certain geographic areas, and also provides that a preference be given within each priority category to hospitals that are members of the same affiliated group with the closed hospital. The priority order is: first, to hospitals located in the same, or a contiguous, core-based statistical area (CBSA) to the closed hospital; second, to a hospital located in the same state as the closed hospital; third, to a hospital located in the same region as the closed hospital; and fourth, if slots still have not been distributed under the first three categories, to qualifying hospitals in accordance with the criteria established under Paragraph 8 of Section 5503 of the ACA, concerning the distribution of additional residency positions.

Moreover, as described within the Federal Register concerning the implementation of Section 5506, CMS articulated a Ranking Criteria, whereby within each of the first three statutory priority categories (that is, same or contiguous CBSAs, same state, and same region), CMS would assign slots first to hospitals that fall within the first ranking category, before assigning slots to those hospitals that fall within the second ranking category, and then

to those hospitals that fall within the third ranking category. See 75 Fed. Reg. 71799, 72216 (Nov. 24, 2010); 77 Fed. Reg. 53258, 53434 (Aug. 31, 2012); 79 Fed. Reg. 50122-50134 (Aug. 22, 2014).

There are currently eight Ranking Criterion. The Ranking Criteria prioritize: assumption of and continued operation of an entire program from the closed hospital (One); use of slots received as part of the most recent affiliation agreement with the closed hospital to continue to train at least those residents it was training (Two); and where the hospital took in displaced residents and will use those slots to continue training the displaced residents until they complete their training, as well as will maintain those slots to continue training others in the same programs as the displaced residents (Three).

For the remaining five criteria, the Ranking Criteria prioritize the planned use of the new slots for primary care or otherwise prioritized residency programs over nonprimary care programs: geriatrics residency program (Four); if located in a Health Professional Shortage Area ("HPSA"), primary care or general surgery residency program (Five); if not located in a HPSA, primary care or general surgery residency program (Six); some used for a primary care or general surgery program, but the program does not meet Ranking Criterion 5 or 6 because the hospital is also separately applying under Ranking Criterion 8 for slots to establish or expand a nonprimary care or non-general surgery program (Seven); and the hospital will use the slots to establish or expand a nonprimary care or a nongeneral surgery program (Eight).

In addition to considering the ranking categories and criteria, Section 5506 requires CMS to only award slots to hospitals where the Secretary "determines the hospital has demonstrated a likelihood of filling the positions made available under [42 U.S.C. § 1395ww(h)(4)(H)(vi)] within 3 years."

Section 5506 – Rounds 8, 9, and 10

As noticed in the 2017 IPPS Final Rule, CMS learned of the closure of three teaching hospitals: Pacific Hospital of Long Beach, CA – 20.47 IME and 25.92 DGME cap slots available (Round 8); Huey P. Long Medical Center, Pineville, LA – 11.04 IME and 11.04 DGME cap slots available (Round 9); and St. Joseph's Hospital, Philadelphia, PA – 8.35 IME and 8.35 DGME cap slots available (Round 10), and is seeking applications in order to redistribute the residency slots. The application period for each of these hospitals is 90 days following the August 2, 2016 Final Rule issuance date. As such, applications are due no later than October 31, 2016.

A separate application is required for each closure, should a hospital wish to apply for slots from Rounds 8, 9, and 10. The applications must be received in hard copy by the CMS Central office no later than October 31, 2016, as postmarking by this date is not sufficient. Applicants must also email CMS a specific message as set forth in the Final Rule, notifying CMS that the application is on the way and providing applicant contact information.

If you are interested in applying for Rounds 8, 9, and/or 10, or would like further guidance or information, please contact David J. Vernon or Marty Corry in Washington, D.C. at 202.580.7700, and Jordan Keville or John Hellow in Los Angeles at 310.551.8100.

CALENDAR

August 3	**Strafford CLE Webinar: Medicaid Managed Care Final Rule: Calculating Medical Loss Ratio, Complying With Network Adequacy Standards and More** Felicia Sze co-presents.
September 12	**Association of Internal Healthcare Auditors Annual Conference, Atlanta, GA** **The 60 Day Rule: Reporting and Returning Overpayment** Lloyd Bookman presents.
September 15	**Heldman Simpson Partners Health Policy Conference, New York, NY** Keith Fontenot is a panelist.
September 16	**HFMA Northern California Fall Conference, Concord, CA:** *Medicaid Managed Care: New CMS Rule and More* Felicia Sze is a presenter.
September 20	**The Los Angeles Medical Group Management Association, Los Angeles, CA:** *MACRA Overview* Charles Oppenheim presents.
October 3-5	**ReviveHealth, Chicago, IL: SUMMITX, 10th Annual Healthcare Thought Leadership Event** Glenn Solomon is a panelist.

CALENDAR

(CONT'D)

October 6	**Clinical Laboratory Management Association, Fall Networking Event, Los Angeles, CA** Nina Adatia Marsden presents.
October 6	**Los Angeles County Bar Association: 13th Annual Healthcare Compliance Symposium** Paul Smith presents and Charles Oppenheim moderates.
October 19	**CCH Webinar: Medicaid Managed Care Final Rule** Felicia Sze presents.
October 27-28	**The 2016 Conference on Health Reform, San Francisco, CA** HLB co-sponsors the conference. John Hellow, Katrina A. Pagonis, Charles Oppenheim, Felicia Sze, Robert Roth, Precious Gittens, Paul Smith, Ben Durie and Nina Marsden present.

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