Some insurers flout prompt-pay statutes that require payment to health care providers within prescribed time periods following submission of a claim. A recent state appellate court ruling in New York can help providers seek relief from such behavior in the Empire State, and may assist providers in other states to enforce similar prompt-pay requirements under their state laws.

Like most states, New York has enacted a prompt-pay statute requiring insurers, within a set period of time following the submission of a claim, to either (1) pay the provider or (2) notify the provider that the claim is being disputed in whole or in part, and specify the reasons for the dispute. Failure to timely comply with New York’s prompt-pay statute exposes the insurer to pay the full amount of the claim, plus interest.

The statute also gives state insurance regulators the authority to impose penalties against insurers that

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violate the statute. This led some plans to argue that the providers did not have the power to enforce the statute by suing a delinquent insurer.

In Maimonides Medical Center v. First United American Life Insurance Co., 2014 N.Y. Slip Op. 01441 (2d Dep’t Mar. 5, 2014), a New York appellate court identified the following issue as one of first impression in that State: can a health care provider sue an insurer to enforce the prompt-pay statute’s requirements and recover amounts owed under the statute? The court answered this question with a clear “yes.”

The underlying lawsuit was brought by a hospital that alleged a Medigap insurer failed to pay approximately $15 million in claims submitted over a four-year period. The lower trial court had denied the insurer’s motion to dismiss in 2012, finding that the prompt-pay statute created an express private right of action whereby providers could sue insurers to enforce the statute’s requirements.

The appellate court disagreed that the statute contained an express private right of action, but nonetheless found that the statute implicitly created such a right. In affirming the trial court’s decision, the appellate court resoundingly rejected the insurer’s argument that private enforcement of the statute was inconsistent with the legislative scheme. The statute “is not simply remedial in nature,” the appellate court explained. Instead, it “affords health care providers and patients certain rights, and imposes an affirmative duty upon insurers to timely pay or dispute claims. In the event of a violation, health care providers and patients are given the right to full payment of the claim plus interest, and insurers are obligated to make such payment.”

The appellate court also rejected the insurer’s reliance on the fact that there had been failed legislative efforts to amend the prompt-pay law to add an express private right of action. It was undisputed that proposed laws which “would have added a section expressly permitting private causes of action were introduced in the Assembly in 2007, 2009, and 2011, and in the Senate in 2011, but were not enacted.” However, the appellate court recognized that “unsuccessful attempts to codify an express private right of action do not establish that the Legislature intended to prohibit private actions. Where, as here, there is no express legislative authorization, whether the violation of a statute gives rise to an independent private cause of action is a matter for the courts . . .” (Internal quotation marks omitted.)

It remains to be seen whether the insurer in Maimonides will seek permission to appeal the recent ruling to New York’s highest court. Furthermore, the possibility remains that other branches of the intermediate appellate court or federal courts could disagree with the recent ruling.

Be that as it may, members of the health care industry directly impacted by the Maimonides ruling—which include a wide variety of health care providers and suppliers licensed in New York State such as hospitals, nursing facilities, physicians, pharmacies, and suppliers of durable medical equipment—should take note of this recent ruling in assessing their options in dealing with recalcitrant insurers. Furthermore, members of the health care industry licensed in other states may find this ruling serves as persuasive law in support of similar remedies under prompt-pay statutes that exist in other states.
California Court Confirms that Non-Network Emergency Room Providers May Sue Health Plans That Negligently Delegate Financial Payment Responsibility to Others; but Declines to Extend the Holding to Hospital-Based Radiologists Providing Non-Emergency Services

By Michael Houske & Glenn Solomon

A recent California court confirmed that non-network emergency room physicians may sue an HMO for negligent delegation of the HMO’s duty to pay providers when its enrollees receive emergency care. In Centinela Freeman Emergency Medical Associates (CFEMA) v. Health Net of California, Inc., et al. (2014) 223 Cal. App. 4th 1366, emergency room physicians who did not have a network contract with a health plan were held to have a viable case against an HMO when the HMO had delegated financial responsibility to another entity that did not pay. The court found that a plan could be liable for negligently delegating financial responsibility to an entity that the HMO knew or should have known was financially unable to pay. The court also recognized that the issue was not just whether the entity had been financially insolvent at the time of the HMO’s delegation, but whether the HMO should have realized that the entity subsequently had become insolvent.

This case has significant implications for providers who do not get paid for emergency services when health plans delegate payment responsibility to entities that either cannot or will not pay what is owed. Health plans typically have argued that the providers only recourse was to pursue payment from the delegated entity. This case reflects that the provider may have the option to sue either the delegated entity, the health plan, or both.

Under California’s Knox-Keene Act, emergency room physicians must treat patients regardless of the patient’s ability to pay, and HMOs must reimburse providers for emergency treatment, even when the providers are not under a written contract with the HMO. The Knox-Keene Act also allows HMOs to delegate their payment obligations to other entities. CFEMA involved a lawsuit by providers against a number of HMOs that had delegated their financial responsibility to an IPA known as La Vida. According to the complaint, La Vida experienced financial problems, failed to reimburse physicians who provided emergency services to the HMOs’ enrollees, and ultimately ceased operating. When La Vida’s financial problems increased, the unpaid emergency physicians sought payment from the HMOs, which simply instructed the physicians to continue presenting their bills to La Vida.

The physicians brought suit against the HMOs, alleging, among other things, negligent delegation. The HMOs had convinced a trial court to dismiss the lawsuit at the pleading stage, but a California Court of Appeals reversed. But the appellate court held that HMOs do have a duty to the emergency providers not to negligently delegate financial responsibility, and that this included a continuing duty to monitor the delegated entity’s payment ability.

Both the trial court and appellate court cited the duty of care factors, but reached different conclusions on how to apply those factors. The factors cited include: (1) the extent to which the transaction was intended to affect the plaintiffs; (2) the foreseeability of harm to the plaintiff; (3) the degree of certainty that the plaintiff suffered injury; (4) the closeness of the connection between the defendant’s conduct and the injury suffered; (5) the moral blame attached to the defendant’s conduct; and (6) the policy of preventing future harm. The trial court concluded that there can be no cause of action for negligence unless the alleged negligent act was intended to harm the plaintiff specifically, as opposed to a class to which the plaintiff belongs, and the trial court found no intent to harm any of the physicians specifically. The appeals court reversed, finding critical (1) whether HMOs may delegate their reimbursement duty to any IPA regardless of the financial stability of that IPA, and (2) whether the
HMOs have a duty not to delegate their reimbursement obligation to an IPA that the HMOs know, or have reason to know, is financially unable to meet that duty. Applying the duty of care factors, the Court of Appeals held that the HMOs had a duty not to negligently delegate to entities that are financially unable to perform the HMOs’ duty to pay emergency providers.

First, CFEMA considered the extent to which the transaction was intended to affect the emergency room physicians, and found that the delegation transaction necessarily was intended to have an effect on the non-contracted emergency room physicians; it had a direct impact on whether they would receive compensation for the emergency services that they provided to the HMOs’ enrollees. In this holding, the Court of Appeals agreed with an older case that also had recognized the negligent delegation theory: Ochs v. PacifiCare of California (2004) 115 Cal. App. 4th 782; and held that an even older case, from more than a decade ago, was incorrect to the extent that it may have held otherwise: Desert Healthcare District v. PacifiCare FHP, Inc. (2001) 94 Cal. App. 4th 781.

CFEMA also found support in the second duty factor, which is the foreseeability of harm to the plaintiffs; the third factor, which is the degree of certainty that the plaintiff suffered injury; the fourth factor, which is the closeness of the connection between the HMOs’ conduct and the injury suffered; and the fifth factor, which is the moral blame attaching to the HMOs’ conduct. As to moral blame, the court discussed the position in which the emergency room physicians found themselves, being required to render services regardless of ability to pay, but having a legal right to be paid by the HMOs; and the position of the HMOs, which had contracted with the patients to arrange, for a price, to provide health care services, including emergency services, with the understanding that those services sometimes may end up being rendered by providers who have no written contract with the HMOs. The CFEMA Court concluded that an HMO could not shirk its legal obligation to reimburse emergency physicians by delegating to an entity the HMO knew or had reason to know to be financially unable to meet this obligation. This would, in effect, have resulted in the emergency physicians being forced to treat enrollees for free.

The Court of Appeal also found support in the sixth factor, preventing future harm, which would be served by imposing a duty on HMOs not to delegate their reimbursement duty to IPAs that they know or have reason to know are financially unsound.

At the same time, however, CFEMA considered a separate lawsuit, filed by a group of hospital-based radiologists, who sought payment from the HMOs on a similar negligent delegation theory relating to the same insolvent delegated entity. These radiologists sought payment for both emergency and non-emergency services. While the same theory was viable for the emergency services that these radiologists provided, the Court of Appeals found that the hospital-based radiologists did not satisfy the negligent delegation theory for the non-emergency services. The decision found that the radiologists were compelled not by law to render non-emergency services, but rather only by their contract with the hospital. Therefore, the hospital-based radiologists were found by the court to be in a different situation when rendering non-emergency services.

CFEMA also distinguished earlier California law that had been brought by the California Medical Association against several HMOs when another delegated entity had gone bankrupt and failed to pay physicians: California Medical Assn. v. Aetna U.S. Healthcare of California, Inc. (2001) 94 Cal.App.4th 151. In that older case, the physicians had entered into written contracts directly with the delegated entity, in which they had agreed to look solely to the delegated entity for payment. By contrast, the physicians in CFEMA had no written contracts with the insolvent delegated entity. Therefore, CFEMA rejected the attempt by the HMOs to extend the older decisions to all situations where HMOs delegated financial responsibility.

This latest California decision reflects a trend that generally has favored non-network emergency providers seeking payment, and cut back on earlier decisions that health plans have tried to use to create broad absolution from their legal duties to pay, by delegating financial responsibility without diligently making sure the delegates could perform.

For additional information or assistance, please contact Michael Houske, Glenn Solomon or Daron Tooch in Los Angeles at 310.551.8111; or Felicia Sze in San Francisco at 415.875.8500; or Joseph LaMagna in San Diego at 619.744.7300.
Risks for Providers Under the Risk Adjustment Program

By David J. Vernon & Katrina A. Pagonis

As managed care organizations and insurance companies (collectively, “insurers”) face increased regulation under the Affordable Care Act (ACA), they are attempting to shift insurance-related compliance obligations to providers. These obligations are sometimes contained in provider agreements as “flow-down” provisions derived from state or federal law. But insurers often seek to impose obligations that either exceed the scope of “flow-down” provisions or that are not legally required. Acceptance of insurance-related compliance obligations create additional financial risks for providers. In this article, we focus on one type of obligation increasingly sought by insurers offering qualified health plans (QHPs) on the new health insurance exchanges (Exchanges or Marketplaces): certification of risk adjustment data.

The ACA’s risk adjustment program is designed to correct for the uneven distribution of healthy and unhealthy individuals that can occur among health plans on the individual and small group market. For the program to function as Congress intended, insurers must provide the government with accurate and complete data concerning the risk profile of their enrollees. This data is then used to determine whether the insurer must pay risk adjustment contributions or will receive risk adjustment payments under the program. Risk adjustment data comes from enrollee diagnoses contained in encounter data forms and paid claim forms as well as more general demographic data contained in enrollment data. Providers supply much of the data that insurers must provide to the government, although insurers control how they test and use that data. Insurers are increasingly asking providers to certify the accuracy of data provided in encounter data forms and claims. As insurers attempt to shift the risks associated with the certification of inaccurate risk adjustment data to providers, providers should understand the compliance obligations and legal risks involved with providing such certifications.

I. Risk Adjustment Program – Data Requirements

The ACA provides for the establishment of three premium stabilization programs. The risk adjustment program, which is set forth in section 1343 of the ACA, 42 U.S.C. § 18063, is designed to correct for the uneven distribution of high- and low-risk enrollees between plans. The other two premium stabilization programs—the transitional reinsurance program (ACA § 1341, 42 U.S.C. § 18061) and the temporary risk corridors program (ACA § 1342, 42 U.S.C. § 18062)—are only scheduled to operate for the first three years of the Exchanges and are designed to further correct for adverse selection and inaccurate premium rating in the non-group and small group markets. Currently, HHS is administering all three programs in most of the country, but states may elect to administer their reinsurance and risk adjustment programs themselves.

The risk adjustment program corrects for the uneven distribution of enrollees between plans and is based on a comparison of plans’ actuarial risks. A plan’s actuarial risk reflects the actual distribution of risk among its enrollees and the expected health care expenditures associated with these enrollees’ care under the plan’s cost-sharing design. Determining a plan’s actuarial risk requires assessing the risk profile of each insured based on their age, sex, diagnoses, and plan metal tier. By way of example, a 62-year-old female enrolled in a silver plan (risk score 0.798) who is diagnosed with diabetes with chronic complications (risk score 1.12) and stroke (1.12) would have a total risk score of 6.133. Once aggregated across all enrollees, this cumulative enrollee risk score is combined with other plan-specific and local data to determine risk adjustment contributions or payments.

Ultimately, low actuarial risk plans (i.e., plans with healthier than average covered populations) and plans that fail to report risk adjustment data will make risk adjustment contributions, while high actuarial risk plans (i.e., plans with sicker than average covered populations) will receive risk adjustment payments. By focusing on actuarial risk rather than claims payments, the risk adjustment program rewards plans that effectively manage the care of high-risk enrollees. Only QHPs and non-grandfathered non-group and small group plans participate in the risk adjustment program.

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Managed Care Contracting Tips In a Consolidating World
By Glenn Solomon & Paul Smith

The surge in consolidations, mergers and acquisitions over the past few years has increased the importance for providers to devote extra attention to contract language affected by these events. Failure to address it during contract negotiations can lead to financial loss and legal disputes down the line – whether months or years later. Moreover, the prevalence of arbitration clauses means that many of these issues have not been vetted by the courts in the managed care context. As a result, there is less formal court authored guidance on risk areas in this field.

Below are some of the key areas where extra attention is warranted in provider-plan contracting to avoid future disagreements:

- **Affiliate.** How does the contract define an Affiliate of the Provider? How about an Affiliate of the Plan? Are both defined? If so, does either definition include just current Affiliates? If so, which current Affiliates are included? Which are excluded? What about future Affiliates? What type of entity can become an Affiliate in the future? Are there any limitations on Affiliates being added? Is there a notice provision to add an Affiliate? Is there an acceptance requirement? If so, must acceptance be affirmative, or does silence constitute acceptance? What grounds permit a party to decline to accept? If the agreement covers benefit plans offered by an Affiliate, who is responsible for payment – the Plan, the Affiliate, both? If it’s the Affiliate, and the Affiliate isn’t a party to the contract, what rights does the contract give the Provider to recover payment if there’s a dispute? Does the contract require the Plan to have an agreement with the Affiliate that requires the Affiliate to pay?

- **M&A.** Some contracts have express provisions addressing what will happen in the event of a merger or acquisition, either by the Provider, or by the Plan, or both. Unfortunately, some contracts do not address this issue expressly, which creates risk of future dispute. From the Provider’s perspective, it may be helpful to clarify whether acquired facilities automatically become covered by the contract, and if so, how rates will be determined for the acquired facilities. Similarly, if the acquired facilities are not automatically covered, what conditions might allow for adding them to the contract? The problem can become even more complicated if the acquired facility has contracts with the same Plan. In these cases, a contract that allows the acquiring Provider to elect to continue the acquired facilities’ pre-existing contracts, or alternatively, to bring them under its own contract, can avoid much heartache and disagreement down the line. Similar issues arise if Plans consolidate: which contact will survive the consolidation, and what choice does the Provider have in the matter?

- **Ownership / Control Changes.** Some contracts have express provisions addressing changes in Ownership or Control. Others ignore the possibility, either for the Plan, or for the Provider, or both. This is not advisable. Issues similar to those that come up with an M&A situation also can come up when Ownership or Control of a company changes. Does the provider really want the contract no matter who Owns or Controls the plan? Or vice-versa?

- **Provider.** How is the Provider defined? By name only? By address only? By tax ID number? By cross-reference to Affiliates? A combination of more than one of these? Although the identity of the contracting entity might seem like something that should be straightforward, the choices made in this definition can affect the scope of the contract in the event of subsequent acquisitions. Typical places to look for this definition include not only a formal definition section, but also the introductory paragraph, the signature page, and the schedules behind the signatures. Moreover, matters can become more complicated if both the acquiring provider and the acquired provider have contracts with the same Plan.
• **Plan.** This definition parallels the one for the Provider, and is meant in this article to refer to the entity that is the other party signing the contract (as opposed to other ways this term is sometimes used, such as to discuss coverage offered – see below). How is the Plan defined? Once again, is it by name only, address, cross-reference to Affiliates, or otherwise? Once again, the choices can affect the scope of the contract in the event of subsequent acquisitions, and it can be more complicated if both the acquiring Plan and the acquired Plan have contracts with the same Provider. Like above, typical places to look for this definition include not only a formal definition section, but also the introductory paragraph, the signature page, and the schedules behind the signatures.

• **Product.** There are a variety of terms that Plans sometimes use to define each of their products. Some examples are program, product, plan (not the entity signing, but the coverage offered to members), etc. Unfortunately these terms are not always used in a uniform fashion. They can vary among Plans, or even vary within a single Plan. They also can be used in overlapping and inconsistent ways, such as a contract with a particular “Plan” entity that is written to include all of its coverage “plans.” Covered Products sometimes include those of Affiliates, and/or Products offered by third parties that the Plan administers. These problems become even more complicated when a Plan has, buys or sells one or more Affiliates. To avoid future disputes, Providers should strive to define the “Product” covered by the contract to make clear exactly what constitutes the Product today, what type of future Products will or will not be automatically covered, what rates will apply to future Products, how the Product differs from the contracting party, and what factors define different Products. For instance, is the Product defined by the network, the scope of the member’s financial responsibility, the level of a member’s out-of-network rights, or in some other way?

• **Payor.** The term Payor also sometimes gets convoluted in contracts with the term Plan, or the term Product, and can create room for disagreement absent consolidation, but even more so when consolidation occurs. The same cautions that apply to the definitions of Plan and Product also apply to the definition of the term Payor. Furthermore, sometimes the term Payor is used interchangeably, or with reference to, the term Affiliate. A Provider can avoid many problems by picking only one term for each of these concepts, defining it expressly, and using it exclusively for that purpose only.

• **Network.** The term Network has seen increasing room for dispute in more recent years, and as with several of the other terms discussed above, can cause problems when two Plan entities join forces, whether through consolidation, merger, or even something they might term an affiliation, even without becoming legal Affiliates.

In sum, there are several different ways that a contract might directly or indirectly affect payment when either providers or plans change ownership. This is not meant to be an exhaustive list of all the terms and issues that can be impacted when managed care entities consolidate. Each set of parties, and each contract between them, can have its own unique set of terms that merit attention to avoid problems when subsequent purchases, sales or other typical and atypical corporate changes occur. These parts of a contract are sometimes discounted, regretfully, as mere boilerplate. But what is boilerplate anyway? Long before managed care, businesses had “boilers,” which needed sufficiently strong “plating” to protect against explosions. In managed care, the explosions from poor boilerplate language may be less deadly, but the financial and relationship consequences of ignoring it in a contract can have serious or even devastating business consequences.

*Hooper, Lundy & Bookman, P.C. has represented providers in contract negotiations with national, regional and local payors. For additional information or assistance, please contact Glenn Solomon in Los Angeles at 310.551.8111 or Paul Smith in San Francisco at 415.875.8500.*
Because a plan’s failure to report risk adjustment data will result in plan liabilities in the form of risk adjustment contributions, plans are incentivized to participate in the program. Furthermore, the omission of relevant diagnoses produces a lower risk score, depressing risk adjustment payments or increasing risk adjustment contributions. Therefore, plans are further incentivized to ensure that all enrollee diagnoses are documented and reflected in risk adjustment calculations. On the other hand, if data overstates enrollee risk scores, the plan may receive an overpayment under the program.

To combat this overpayment and underpayment risk, where HHS administers the program, it imposes data validation and auditing requirements on plans, and requires that plans submit or make available risk adjustment data for additional HHS audits. The failure to adhere to these requirements may result in civil monetary penalties under 45 C.F.R. section 153.740. For the first two years of the program, HHS will refine its data validation process based on its observation experience. In subsequent years, payments and charges will be adjusted based on error rates. However, HHS specifically noted that “other remedies, such as prosecution under the False Claims Act, may be applicable to insurers not in compliance with the risk adjustment program requirements.”

II. The Providers’ Role

HHS has acknowledged that insurers to some extent “depend on providers, suppliers, physicians, and other practitioners” to submit risk adjustment data (particularly diagnoses) to insurers. Accordingly, the regulations explicitly permit, but do not require, an insurer to include data submission requirements in provider agreements:

An insurer that offers risk adjustment covered plans may include in its contract with a provider . . . provisions that require such contractor’s submission of complete and accurate risk adjustment data in the manner and timeframe established by the State, or HHS on behalf of the State. These provisions may include financial penalties for failure to submit complete, timely, or accurate data.4

But plans and providers remain free to negotiate whether, and if so to what extent, to have risk adjustment data terms and conditions in their managed care agreements. This includes negotiating any additional compensation that the plan may have to pay the provider for the added work and risk entailed, should the provider agree to aggregate, prepare, certify, or otherwise handle such data.

Providers face increasing pressure from insurers to accept obligations with regard to risk adjustment data. At times, a plan might incorrectly contend that the risk adjustment provision is legally mandated, and therefore, legally non-negotiable. In other cases, a plan may seek to amend an existing contract to include such obligations, often asserting that the amendment is legally required, although no such requirement exists. We also have become aware of situations in which insurers have asserted that providers are legally required to certify data, even when the provider has no such obligation under the applicable managed care agreement. These activities attempt to shift responsibility for risk adjustment data to the provider level, often without the offer of additional compensation to cover the labor and risks involved.

Where providers undertake activities involving risk adjustment data, they may encounter potentially significant risks. HHS has explicitly stated that, in addition to insurer-focused enforcement remedies set forth at 45 C.F.R. section 153.740(a), additional remedies “may be available through other Federal statutes, such as the False Claims Act, as well.”5 Because a provider’s knowingly false certification of risk adjustment data (including the certification of such data with reckless disregard for its accuracy and validity) may constitute a false certification actionable under the False Claims Act, we recommend that providers proceed with caution before undertaking any risk adjustment certification activities. In addition, we also advise that providers carefully review any risk adjustment data provisions in their existing managed care agreements, and in any proposed provisions, to fully understand the risks and compensation.

III. Conclusion and Outlook

As insurers confront growing compliance obligations under state and federal law, they are increasingly likely to attempt to shift or share their risks with providers wherever possible. In some cases, insurers are required by a State-Based Exchange to include certain language in their managed care agreements.
In addition, insurers of QHPs offered on Federally Facilitated Exchanges are subject to certain contracting requirements for delegated and downstream entities, which may include participating providers. However, we have frequently seen insurers go beyond the scope of these legal requirements and attempt to impose additional or more expansive obligations on participating providers. In the case of providers’ risk adjustment data obligations, we do not believe that federal or state law mandates the inclusion of such obligations in provider agreements at this time.

We therefore recommend that providers carefully review proposed managed care agreements and amendments thereto and consult with counsel, particularly where they are being asked to undertake additional or atypical obligations. Because of the rapidity of legal changes for QHPs, it is particularly important that any agreement that might cover individual and small group products be analyzed and evaluated for unnecessary legal obligations and other areas of risk. While managed care negotiations concerning QHP participation often occur under perceived time constraints, we believe that the speed at which QHP legal requirements are evolving and the novelty of various health care reform programs necessitate careful consideration and review.

For additional information or assistance please contact Katrina Pagonis or David Vernon in San Francisco at 415.875.8500; John Hellow or Glenn Solomon in Los Angeles at 310.551.8111; or James Segroves or Ariana Ornelas in Washington, D.C. at 202.580.7700.

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4 45 C.F.R. § 153.610(c).
May 9  SCAHRM Annual Conference  
Steve Lipton and Nina Adatia Marsden present the Legislative Update.

20-21  Revive Annual Healthcare Summit, Nashville, TN  
Glenn Solomon presents Managed Care Update

24  Southern California Healthcare Executives  
Lillie Werner presents Is Your Organization at Risk?  
Trends that Healthcare Executives Should Know.