Clinical Co-Management, Managed Care Contracting and Assignment of Benefits

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This Health Law Alert's lead article addresses the healthcare compliance challenges facing hospitals and physicians due to their aligned interests in co-management arrangements. This article also identifies the sources of best practices to avoid non-compliant co-management arrangements.

The second article examines two 2010 Texas cases affecting managed care contracting and the third article discusses a 2010 Texas case addressing the assignment of rights to sue for a health plan's breach of its fiduciary duties. These articles highlight changes that may be necessary in providers' managed care contracts and patients' assignments of benefits.

Clinical Co-Management Arrangements: Aligned Interests and Compliance

Clinical (or service-line) co-management arrangements are one of the strategies hospitals and physicians are using to achieve clinical integration, strategic alignment and collaboration. A co-management arrangement is an incentive-based compensation model, in which the hospital and the physicians are held responsible and accountable for achieving performance standards. Clinical co-management may be a useful intermediate step to payment bundling, accountable care organizations or other pay-for-performance initiatives arising under healthcare reform. There are special and compelling mutual interests involved in clinical co-management:

- Lowering hospital costs
- Achieving operational efficiencies
- Improving quality and patient outcomes through care coordination, evidence-based medicine, and outcomes measurement and reporting
- Increasing profitability, patient satisfaction, physician recruitment, physician retention, and other value-driven goals

These mutual interests are achieved in a clinical co-management arrangement by the hospital giving up part of its managing control, and the physicians receiving compensation and incentives for achieving performance standards and satisfying other co-management responsibilities. The pay-for-performance structure is based on fixed and at-risk compensation, which must be documented and supported by a detailed valuation of fair market value.

According to Ed Conlon, Associate Dean for Graduate Studies at the University of Notre Dame, Mendoza College of Business, aligned interests "…create a shared bias toward action – a universal desire to move ahead with strategies and tactics that serve those interests." Dr. Conlon warns that "…when interests are well aligned behind a course of action, greater diligence is needed to make sure the full range of risks and consequences of failure are well understood and fully appreciated." Dr. Conlon notes that (i) aligned business interests, (ii) special incentives and profit opportunities, (iii) uncertainty or ambiguity, (iv) questionable assumptions, (v) challenging levels of complexity, and (vi) well-intentioned but relaxed oversight by key decision makers may result in acceptance of undue risks and overlooked or ignored compliance concerns.

Co-management arrangements, like any physician and hospital integration strategy, generate legal issues under antitrust, anti-kickback, civil monetary penalties, physician self-referral prohibitions, tax exempt organization requirements, and Medicare laws and rules. Best practices for avoiding liability of co-management agreements under these laws and regulations may be gleaned from (i) Office of Inspector ("OIG") Advisory Opinion, 08-16, (ii) the proposed Incentive Payment and Shared Saving Programs exception and preamble published by the Centers for Medicare and Medicaid Services, (iii) The Joint Commission manuals on quality and performance management, and (iv) OIG corporate integrity agreements ("CIA") involving noncompliant hospital/physician integration arrangements, e.g., the OIG's recent CIA with St. Joseph Medical Center in Towson, Maryland.

Dr. Conlon describes aligned companies and their executives as having "…enormous responsibilities at the top to ask the right questions and to insist on thoughtful and honest answers…" Best practices and compliance for new and untried arrangements for hospital and physician alignment should be discussed with experienced healthcare counsel.

Managed Care Contracting: Know Your Legal Precedents to Avoid Payment Disputes

Healthcare providers often contract with network-type preferred provider organizations ("PPO") that secure reduced rates for the PPO's subscribers, such as insurance companies, third party administrators ("TPA"), and employer-sponsored health plans. The PPO's subscribers, referred to as "Payors" in the provider's contract with the PPO, receive, review, and pay the claims for the provider's services. As part of a subscriber agreement between a Payor and a PPO, the Payors are usually required to sign a "Payor Acknowledgement" form that contractually binds the Payor to pay claims in accordance with the provider/PPO contract. If the claim is not paid promptly, or is underpaid, the Payor loses eligibility for the reduced rates and must pay the provider's billed charges.

Two recent cases, both involving Baylor Health Care System hospitals ("Baylor") and Private Healthcare Systems ("PHCS"), a network PPO, demonstrate how the interaction of the hospital services agreement ("HSA"), the subscriber agreement and the Payor Acknowledgment may produce different rulings. In the January 2010 case, *Baylor University Medical Center, et. al. v. Nippon Life Insurance Co. of America*, Nippon, the subscriber, contracted with PHCS and signed a Payor Acknowledgment agreeing to pay claims according to PHCS agreements with hospitals, physicians and other healthcare providers. A dispute arose regarding Nippon's payments under Baylor's HSA with PHCS. Contending that Nippon's Payor Acknowledgement bound it to all of the terms and conditions of the HSA, Baylor sued Nippon to compel arbitration to resolve the claims dispute, as provided in the HSA, alleging Nippon's ineligibility for the reduced rates due to Nippon's late payments and underpayments.

Nippon countered that its subscriber agreement with PHCS was specifically designed with the stated intent of not creating privity of contract between Baylor hospitals and Nippon. Baylor, citing the precedent of the 2004 case of *Baylor University Medical Center, et. al, v. Epoch Group, L.C.*, also involving an HSA with PHCS, argued that the HSA, subscriber agreement and Payor Acknowledgment should be read as a single, unified contract.

The court disagreed with Baylor stating the precedent applied only to disputes over payment, not to other HSA provisions. Since the HSA, subscriber agreement and Payor Acknowledgment had different parties, the absence of an arbitration term in the subscriber agreement meant the documents could not be read as a single, unified contract for purposes of arbitration of claims with PHCS and preferred providers, including Baylor. The court also ruled that Baylor's equitable estoppel argument—Nippon had benefited from the HSA and could not claim not to be subject to it—failed because Nippon was not a party to the HSA. The court noted that Nippon's benefits of the reduced rates, while described in the HSA, came as a result of the Payor Acknowledgment and not the HSA. Further, the court noted that a "no third party beneficiary" provision in the HSA, and a choice of law provision in the subscriber agreement selecting more restrictive New York law, meant that Nippon was not bound to arbitrate with Baylor. The Nippon case shows how privity of contract and "boilerplate" provisions may combine to defeat the provider's remedies and rights in a managed care contract.

A favorable outcome for Baylor occurred in the December 2010 case, *Baylor Health Care System, et. al. v. Insurer Administrative Corp.* This case involved the failure of Insurers Administrative Corp. ("IAC") to pay four claims within the prompt payment period of the HSA between Baylor and PHCS. IAC and Baylor agreed that the HSA, subscriber agreement and Payor Acknowledgement should be read as a single, unified contract, but disagreed as to the extent of IAC's obligations and liabilities. IAC argued that the Payor Acknowledgment obligated IAC to "arrange to pay" claims in a timely manner, not to actually pay them, and further cited the distinction between "Payors" and their "designees" in the HSA. The court disagreed and stated the Payor Acknowledgement unambiguously required IAC to pay the claims as it established IAC's status as a "Payor". Further, the court ruled the HSA explicitly relieved PHCS from liability for claim payments and instead required PHCS to obtain Payor Acknowledgements from subscribers such as IAC.

IAC argued that the damages provision of the HSA was an unenforceable liquidated damages provision. Under Texas law, a liquidated damages provision is defined as an acceptable measure of damages that parties stipulate in advance will

be assessed in the event of a breach. The court ruled that failure to pay a claim within the prompt pay period was not a contract breach; rather, it rendered IAC ineligible for the discounted rates. However, the court ruled IAC's failure to pay billed charges when paying a claim outside the prompt payment period was a breach of the contract, and the damages for such breach was the difference between the amount of billed charges owed to Baylor and the amount actually paid by IAC.

Even if the damages clause were a liquidated damages provision, the court ruled that IAC did not prove it was unenforceable. The court explained that adding interest to IAC's late payment was an insufficient measure of Baylor's damages. The court did not accept IAC's position that billed charges were not a reasonable estimate of just compensation. The court noted billed charges represent the amount any person would pay absent specially contracted discounts, and thus constitute a reasonable estimate of just compensation. IAC offered no evidence that the billed charges themselves were unreasonable. This case demonstrates the importance of definitions and breach/damages provisions in managed care contracts.

Texas managed care precedents are essential knowledge areas for providers in obtaining correct and prompt payment and in preserving their rights in managed care contracts. Healthcare providers should seek the advice of experienced health law counsel for managed care contract negotiations.

Assignment of Benefits: Establishing Derivative Standing

Under the Employee Retirement Income Security Act of 1974 ("ERISA"), a civil lawsuit may be brought against a health plan by a plan participant, beneficiary or fiduciary for a breach of the plan's duties. The right to sue may be assigned, giving the assignee derivative standing in the lawsuit. Healthcare providers may claim such standing by receiving a valid assignment from their patients. An assignment of benefits ("AOB") that merely grants the right to recover benefits or receive payment for services rendered does not effectively assign the types of claims that a provider may want to assert under ERISA.

Typically, a provider will desire to bring claims for breach of fiduciary duties under ERISA against the health plan alleging its failure, among other duties, to:

- Act without unreasonable delay with respect to authorizations for treatment
- Act with the care, prudence and diligence that a prudent plan and/or fiduciary would use
- Provide a full and fair review of the claim
- Comply with claims procedures
- Provide plan documents

Only an express and knowing assignment of an ERISA breach claim is valid. If an AOB refers to the patient's assignment of "all rights, title and interest in all benefits payable for the healthcare rendered", the AOB has not referred to the plan's fiduciary duties, but, instead has limited the AOB to the "benefits payable." The provider has not acquired standing to sue under ERISA for breach of fiduciary duties. Further, if the AOB describes the patient's grant of an "independent right of recovery to pursue administrative remedies or lawsuits against the plan to collect benefits," the AOB has narrowed the types of remedies or lawsuits to collection of benefits payments and excluded claims for breach of fiduciary duties. Many providers include such mistaken provisions in their AOBs.

A recent November 2010 case involving alleged intentional delayed payment for hospital claims, *North Cypress Medical Center, et. al. v. Med Solutions, Inc.*, focused on an AOB that did not properly establish derivative status for the hospital. Obtaining specific and valid AOBs from patients, with the assistance of experienced healthcare counsel, will permit providers to maintain lawsuits for an insurer's or third party administrator's failures in the prepayment review process or failure to pay claims promptly.

Contacts:

Lewis A. Lefko | 214.745.5273 | llefko@winstead.com
Cheryl S. Camin | 214.745.5142 | ccamin@winstead.com