

Managed Care **COMPLIANCE ALERT**

News & Analysis On Regulatory Compliance & Quality Assurance For Managed Care

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Managed Medicaid

GOVERNORS SAY BBA REGS COULD KILL MEDICAID MANAGED CARE

When it comes to reforming managed Medicaid programs across the country, managed care organizations and state governors for once are finding themselves allies.

Both the **American Association of Health Plans** and the **National Governors Association** are stepping up pressure on Congress and the Bush administration to lessen administrative burdens on Medicaid MCOs and to increase the federal government's financial responsibility for Medicaid.

Managed care has assumed a more and more substantial role in delivering benefits to Medicaid beneficiaries. Medicaid managed care enrollment grew steadily from 1996 to 2000, from 40 percent of the total Medicaid population to almost 56 percent, according to the most recent data from the **Centers for Medicare & Medicaid Services**.

At the same time, MCOs' participation in managed Medicaid declined by almost 20 percent during that same time period; other types of health plans gained members. "A number of MCOs have recently ended their involvement in Medicaid," points out the AAHP in its most recent policy brief on Medicaid managed care, "Enrollment and Plan Participation Trends in Medicaid Managed Care, July 2001."

The AAHP names "low state reimbursement rates, the high cost of administering Medicaid programs, and the complexity of Medicaid regulations" as the main factors in MCOs' decisions not to participate in Medicaid programs. "Going forward, low state reimbursement rates and new regulations that complicate health plan participation jeopardize the contributions managed care plans have made to improving the health of Medicaid recipients," says the brief.

After the initial involvement of MCOs in Medicaid's "healthy moms and kids" programs, a new wave of more difficult to treat populations — dual eligibles, disabled, special needs kids and lower-in-

Claims Payment

FL HMOs SKIRTING PROMPT PAY WITH MEMBER QUESTIONNAIRES

If your organization operates an HMO in Florida, now is the time to thoroughly review its prompt pay compliance efforts. The Florida Department of Insurance is investigating HMOs' compliance with the state's prompt pay law, and the Florida Medical Association is pushing for revisions of the law. (Page 27)

come seniors — have proven to be “more difficult projects to undertake,” explains an AAHP official.

MCOs involved in Medicaid programs face regulations that their commercial counterparts don't, the official tells **Eli**. For example, Medicaid MCOs that do business in states with multilingual populations must provide all their plan material in all those languages. “There's a higher number of requirements on these plans,” the official says.

CMS' proposed Medicaid managed care regulations under the Balanced Budget Act of 1997 are also a sore spot for MCOs. The AAHP has submitted formal comments complaining about regulatory burdens imposed by the proposed rule, which the Clinton administration released Jan. 19, 2001, and the Bush administration revised in August.

The NGA, which met in February in Washington for its annual winter meeting, is concerned about the Medicaid managed care regs, too. “The proposed rules would create so many barriers for states to implement mandatory managed care through the state plan amendment option that it would not become a valid option at all,” according to the NGA's updated Medicaid reform principles. “Further, the decision to apply an entirely new set of prescriptive regulations to currently existing 1915(b) and 1115 waivers could very well result in the end of Medicaid managed care.”

The NGA is also worried about federal cost-sharing proposals that would shift more costs to the states and about the need for governors to have the “maximum flexibility” in designing programs for optional and mandatory Medicaid populations, says NGA spokesperson **Christine LaPaille**. Furthermore, the governors are alarmed by proposals to reduce federal matching percentages and are organizing to ask Congress to increase funding for Medicaid programs, according to both the AAHP official and the NGA's policy statement.

The matching issue is important to health plans because “if the states can't get money elsewhere, they will reduce reimbursement to providers rather than cut benefits or raise taxes,” the AAHP official explains. “The more money states can get, the more money they'll have to reimburse providers, including health plans.”

MCOs will likely have an opportunity to work with the governors to put pressure on Congress. The NGA at its winter meeting decided to establish an independent Commission on Medicaid Reform Policy that will be responsible for bringing these issues to Congress' attention. While the composition

of the commission is still undecided, “there will be private sector membership,” says LaPaille. “All the players need to have some representation on the commission for it to work.” ❖

Litigation

STATE LAWS AGAINST PRIVATE ACTION BAR MEMBER RICO SUITS

Both sides are claiming victory following another mixed ruling in the Florida multidistrict managed care litigation, but only the HMOs are appealing Judge **Federico Moreno's** partial dismissal of the member plaintiffs' ERISA claims.

Moreno, who sits on the **U.S. District Court for the Southern District of Florida** in Miami, on Feb. 20 granted some of the defendant HMOs' motions to dismiss but allowed other claims brought by the HMOs' members to proceed. Moreno has allowed some of the members to refile their claims, and there are now two groups of subscriber-track plaintiffs: those who are still members of the HMOs and those who are not.

In the subscriber track of *In re: Managed Care Litigation*, the plaintiffs charge **Aetna, CIGNA, Health Net, Humana, Prudential** and **UnitedHealth Group** with denying care and withholding information on the influence of business imperatives on medical decisions.

A separate provider track handles complaints brought against the same group of MCOs by physicians across the country. **PacifiCare Health Systems** and **WellPoint** are still involved in the case's provider track.

In his latest decision, Moreno ruled that six of 16 subscriber plaintiffs could go ahead with fraud claims under the Racketeer Influenced and Corrupt Organizations Act. Moreno threw out the other 10 RICO claims on the grounds that state regulations in Florida, New Jersey, California and Virginia conflict with federal RICO claims. These four states have laws that bar private causes of action for insurance fraud.

Moreno made the reverse-preemption decision based on the McCarran-Ferguson Act — “a law that Congress passed to prohibit federal lawsuits that encroach upon the state regulatory decision-making process,” according to the ruling.

The remaining plaintiffs hail from Texas and Mississippi; plan members from other states that allow private cause of action for insurance fraud could still join them. Plaintiffs' attorneys were stal-

wart in response to the ruling. “The core issues in the case are still part of the case,” says **Stephen Neuwirth** of **Boies Schiller & Flexner** in New York.

But “there’s no way now that the plaintiffs can establish a nationwide class for RICO purposes,” **Stephanie Kanwit**, senior vice president of the **American Association of Health Plans**, tells **Eli**.

Moreno also threw out some of the members’ claims brought under ERISA that charged the MCOs with inadequately disclosing coverage in summary plan descriptions. In these claims, the subscribers argued that plans didn’t use the term “medical necessity” in its conventional sense and that the MCOs’ medical decisions are improperly influenced by financial concerns.

“All that’s left in the ERISA [claims] is the gag clause,” says Kanwit. “As far as we’re concerned, it’s a non-issue,” she avers. Moreno left intact the members’ claims that the MCOs breached their fiduciary duties under ERISA by enforcing “gag orders,” or restrictions on what physicians can tell members about their health coverage options.

These plans do not use gag clauses that interfere with the doctor-patient relationship, says Kanwit, citing a **General Accounting Office** study. “I can’t imagine how the plaintiffs are going to get restitution of premiums for the existence of gag clauses that don’t even exist,” she maintains.

Moreno refused to dismiss the non-members’ ERISA claim that the HMOs’ failure to disclose financial incentives is a misrepresentation that breaches their fiduciary duty under ERISA, but he did say that “these plaintiffs should be aware of the fragility of their claims.”

“The plaintiffs replied their summary plan description claim by stating that the defendants ‘inaccurately described the medical necessity definition actually applied during the claims review process,’” says Moreno. If all the plaintiffs are doing is re-alleging that the HMOs fail to give them enough information about cost-suppression incentives to put “medical necessity” in context, that claim will once again fail, says the judge.

On March 1, Aetna, CIGNA, Health Net, Humana, Prudential, and United asked Moreno to reconsider his Feb. 20 ruling, complaining that he should have dismissed those former subscribers’ fiduciary duty misrepresentation claims as well as all the plaintiffs’ gag-order claims.

The HMOs on March 1 also filed a request that the **11th U.S. Circuit Court of Appeals** review Moreno’s decisions on “these important threshold

questions” at this point in time, “[b]ecause the next stages of the litigation have ‘the potential to consume vast resources from all litigants,’” according to the motion for interlocutory review.

The decision over class certification is Moreno’s next step. “It is worth noting that the [11th Circuit] has never upheld class certification in a RICO case,” says Aetna in a statement. ❖

Claims Payment

FL HMOs SKIRTING PROMPT PAY WITH MEMBER QUESTIONNAIRES

If your organization operates an HMO in Florida, now is the time to thoroughly review its prompt pay compliance efforts. The **Florida Department of Insurance** is investigating HMOs’ compliance with the state’s prompt pay law, and the **Florida Medical Association** wants the law revised.

“There’s a review going on of all the HMOs in Florida under prompt payment legislation passed two years ago,” a spokesperson for the FDOI tells **Eli**. So far the FDOI has issued nine consent orders to HMOs addressing problems the department found in reviews of their claims payment processes.

And there could be more. “The review process will happen with all the state’s HMOs,” says the spokesperson, who said the FDOI could not yet issue the names of the HMOs involved in the ongoing investigation. The FDOI licenses 34 HMOs in the state, nine of which are currently winding down and not writing any new business, according to the agency’s most recent HMO directory.

The HMOs received the consent orders in mid-February and have 30 days to respond, the FDOI spokesperson explains. They have three options: sign the consent orders, ask for an administrative hearing to dispute the FDOI’s review, or refuse to sign the orders. “If they refuse to sign, there’s the potential for administrative action,” the spokesperson says. “But we assume that will not be the case.”

Under Florida’s prompt pay law, plans have 35 days to pay providers. “We recently passed prompt pay legislation,” said FMA President **Dr. Terence McCoy** at the time, “but this legislation does not work as long as the HMOs continue to find loopholes in the law.”

Providers say HMOs are currently exploiting a loophole by pending claims payment on the gathering of extra information from members. A patient account representative at a provider in Orlando, FL tells **Eli** that HMOs — contracted and

non-participating, small and large, government programs and commercial — are refusing to pay claims until members return questionnaires, accident details or preexisting condition information to the HMOs.

“We try to get in touch with the members to tell them to get in touch with the insurer and tell it what it needs to know so that the claim can be processed,” says the account rep. “But patients are nonresponsive to us and to the insurance company.”

Claims aren’t paid for months — long after the 35-day deadline plans would otherwise have under the prompt pay law. Providers have had to piece together the problem by auditing their accounts receivable and finding that the HMOs’ practice of pending claims is producing this new version of unpaid claims.

Providers are caught because the HMOs tell them they’re not allowed to bill the members, and their contracts with the HMOs don’t address the situation. “No one thought this would be an issue when the contracts were drafted,” says the account rep, who adds that hospitals are no better off in this situation, even though the HMOs often tell the providers to have the hospitals, where the services were performed, contact the members.

“Our claims are clean,” says the account rep in Orlando. “We’re told [by the HMOs] that there is nothing wrong with claims but that nothing can be released until they receive the [member] information.”

The FMA maintains that the HMOs are able to do this because Florida’s definition of clean claims is unclear. “Under current prompt pay laws the HMO can require a survey, but it must be for substantiating evidence to process the claim,” says FMA spokesperson **Lisette Gonzalez Mariner**. “We don’t think HMOs can use a patient survey or satisfaction survey. It’s got to be part of the claim.”

The FMA is pushing legislation this year that would remove the definition of clean claims and clear up the problem, says Gonzalez Mariner. Under Florida HB 293 and SB 362, “all claims would have to be removed or disputed within a certain time frame,” she explains. “On both ends.” ❖

State Regulation

LEGISLATORS SEEK TO DEFINE ‘MEDICAL NECESSITY’ IN 2002

Prompt pay, health plan liability and coverage mandates continued to attract the attention of state legislatures in 2001, and industry groups say managed care organizations can expect to see similar trends continue into 2002.

The **Blue Cross Blue Shield Association** and the **Health Insurance Association of America** recently published analyses of state legislatures’ action on health care issues affecting MCOs.

Prompt Pay. Thirty-one states “introduced bills that would either clarify the application of current guidelines, stiffen existing standards or adopt new ones, and 15 enacted such legislation,” according to BCBSA’s annual “State of the States” survey released Feb. 14. “The total number of states with prompt pay laws or regulations has now reached 48.”

HIAA reports slightly more action on the prompt pay front: “This year, legislation was introduced in 33 states,” says HIAA, “with 18 adopting more stringent standards.” HIAA counts laws passed in the District of Columbia, Illinois and New Jersey as being passed in 2001 although New Jersey, for example, passed a prompt pay law in December 1999 and updated it in 2001.

Health Plan Liability. While nearly half of the states considered liability proposals last year, only four — New Jersey, North Carolina, Oregon and West Virginia — enacted them, says BCBSA.

Oregon passed a rather ambiguous law that makes a plan’s exposure to lawsuits dependent on its decision whether to abide by independent review organizations’ determinations, according to BCBSA: “[I]f a health plan chooses not to be bound by the reviewers’ decisions and fails to comply, then an enrollee may sue for damages arising from an adverse decision.”

Health plan liability “[b]ills in Delaware, the District of Columbia, Illinois, Iowa, Kansas, Massachusetts, Michigan, Minnesota, New York, Pennsylvania, Rhode Island and Tennessee will carry over to 2002,” says HIAA.

Mandates. During 2001, every state introduced bills mandating new benefits,” according to HIAA. “Overall, more than 550 new mandates were introduced, and 65 became law.” Delaware, Illinois, Indiana and Kansas enacted mandates to cover a limited type of mental health parity, and Connecticut, Maryland and Oklahoma now require coverage of hearing aids, says BCBSA.

In a bit of good news, “a countervailing trend” emerged in 2001 as eight states “took action to curb the proliferation of mandated health benefits by requiring that cost-benefit analyses be performed,” adds BCBSA. The eight states are: Arkansas, Hawaii, Louisiana, New Jersey, North Carolina, North Dakota, Texas and Vermont.

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Other Issues. External review and utilization review caught the attention of a handful of states, according to HIAA. States also passed laws regulating pharmacy access and pricing, expanding coverage for the uninsured and implementing the privacy provisions of the federal Gramm-Leach-Bliley Act, says the BCBSA.

Of the 46 states that considered GLBA legislation, says HIAA, 32 passed privacy legislation and 36 promulgated regulations under GLBA.

Antitrust legislation designed to allow physicians to bargain collectively with plans was largely unsuccessful. Seventeen states introduced legislation in 2001, but only New Jersey joined Texas as the second state to adopt antitrust waivers.

2002 Forecast. Benefit mandates will continue to be a hot item in the states in 2002, according to both the BCBSA and the HIAA. Every state legislature in session — 44 plus the District of Columbia — “will consider proposals to require health insurers and health plans to pay for specific services,” the HIAA says.

In addition, the HIAA says MCOs can also expect states to continue to restrict utilization review decisions, to establish statutory definitions of “medical necessity” and to re-examine previous market “reforms” as leading issues in 2002.

Continuing a “troublesome” trend that emerged just last year, “provider groups will pursue special interest legislation that would require health plans to make direct payments to non-participating healthcare providers, with potentially harmful effects on consumers,” adds BCBSA. “Health plan liability legislation will continue to be championed by the trial bar and medical establishments in selected states, but will face an uphill struggle due to cost concerns.” ❖

Compliance Plans

CRAFT HOTLINE POLICIES TO MAKE ROOM FOR INVESTIGATIONS

If your employees are unwilling or unable to report compliance violations, you might as well hang up a sign saying “Whistleblowers Welcome.”

Providing your employees with several options to report concerns increases the chances your organization will hear about a problem before the feds do, experts say. A meaningful and responsive telephone hotline is one of the best defensive measures you can take, according to Los Angeles-based whistle-blower attorney **Mark Kleiman**.

Creating and maintaining reporting mechanisms has become more challenging with recent technological innovations. Without anonymity, your reporting mechanism will fail, warned attorney **Michael Roach** with Chicago-based **Michael Best & Friedrich**. Caller ID can complicate providing an effective hotline, Roach told listeners at an **Eli** audio conference Jan. 17.

One solution is to set up a separate phone line, without caller ID, and explain to employees that the compliance officer will not pick up that phone but will listen to the message the caller leaves, Roach suggested. And tell employees they can always call from a pay phone, he added.

Using e-mail to report compliance concerns makes anonymity difficult, said Roach. Many entities stick with the old-fashioned acceptance of written reports to get around anonymity challenges.

Implementing an effective reporting mechanism is a crucial first step, but you must demonstrate to reporters that you are taking their concern seriously, Kleiman says. Take appropriate action on the tip, then don't hesitate to report back to the employee, counsels attorney **Nicholas Harbist** with the Cherry Hill, NJ office of **Blank Rome Comisky & McCauley**. Deal with the problem internally, he advises, because if you ignore it you may find yourself dealing with the government instead.

Retaliation against a reporter destroys your compliance program's effectiveness, Roach warned, so be careful to protect an employee who reports a problem with a supervisor.

But keep in mind that confidentiality is a “give and take issue,” attorney **Juan Bellido** with **Rosenberg & Schapiro** in Boston tells **Eli**. If a reported matter enters the internal investigation phase, your organization needs to have the ability to verify the facts behind a caller's report.

“If you put forth a policy that says, ‘We're going to protect confidentiality no matter what,’ you're letting yourself into an open field for calls reflecting grudges and baseless allegations, with no responsibility on the person making the call,” says Bellido, whose firm helps craft compliance plans for health care organizations.

The key is crafting a balanced confidentiality policy. To improve your reporting mechanism, educate staff about how to report, investigate promptly and keep accurate records, say experts.

The hotline is useful if the organization or entity sets it up as the point of input that allows an employee to not only report an incident but also to

go on and provide supporting information, says Bellido, who agrees that offering untraceable, dedicated lines becomes important in that respect.

He suggests that organizations use an internal screening mechanism to ensure that the compliance committee or officer review allegations received via the hotline before making any determination about what type of investigation is necessary in response.

“We have recommended that clients say things like ‘the organization will maintain confidentiality to the extent it’s possible to do so,’” explains Bellido. “We’ve crafted language that alerts employees that if further discussion or verification [of the facts] is needed, there will be some need to verify the identity of people involved or the nature of allegation.”

But the bottom line is that the organization needs to “make sure the policy nurtures the sense that whatever the callers’ thoughts or allegations are, it’s not going to deem them as ridiculous or ‘just a grudge,’ and that it’s going to investigate and review everything,” Bellido concludes. “If the actual allegations are determined to be a problem, it’s better to address and handle them in-house, before they surface.”

“Then, after corrections or adjustments have been made, carefully determine if the entity needs to consider self-reporting to the government,” Bellido says. “To get to that point and to have the ability to decide such issues accurately, a ‘confidential’ hotline and screening process are important.” ❖

Industry Notes

NCQA PROPOSES REDUCTION IN ACCREDITATION BURDENS

MCOs should prepare now for accreditation changes coming their way over the next two years. The **National Committee for Quality Assurance** announced March 1 that it is revising its 2003 accreditation standards for MCOs, managed behavioral health organizations and PPOs.

Proposals that the NCQA says will reduce burdens on plans include the elimination or modification of “several standards that historically have required extensive documentation of MCO activities in the areas of measurement, intervention, follow up, and evaluation of clinical quality improvement activities.”

NCQA expects to measure plans’ success in improving clinical quality by evaluating their performance on certain HEDIS and CAHPS measures. NCQA also proposes to revise utilization manage-

ment measures to “make NCQA’s standards consistent with state and federal **Department of Labor** regulations in the same area, helping to reduce the total oversight burden for health plans.”

MCOs have until April 1 to comment.

In Other Compliance News:

- MCOs won’t be catching any further breaks on the compliance deadline for the DOL’s final managed care claims regulation, **Robert Doyle** of the **DOL Pension and Welfare Benefits Administration** told health plans at the **American Association of Health Plans’ 2002** policy conference Feb. 27. Employee benefit plans must revise their appeals and claims procedures by Jan. 1, 2003 at the latest, under the last extension granted by the Bush administration in July 2001.

“We’re not going to provide any more extensions of time on that deadline,” elaborates a PWBA spokesperson. Nor is the PWBA “actively considering any amendments to it,” the spokesperson adds. Doyle also said the claims reg is “already consistent” with proposed patients’ bills of rights in the House and Senate.

- Compared to 2001, Medicare+Choice organizations can expect little change in the 2002 HEDIS reporting requirements, which CMS posted Feb. 7. Go to www.hcfa.gov/stats/hedisru02.htm. ❖

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