

Managing Risk: Legal and Liability Issues In a Managed Care Environment

PRESENTED BY: WHITNEY MAGEE PHELPS
FROM GREENBERG TRAURIG

Introduction & Housekeeping

Housekeeping:

- Slides are posted at [MCTAC.org](https://mctac.org)
- Questions not addressed today will be:
 - Reviewed and incorporated into future trainings and presentations
 - Added to Q&A resources when possible
- Feedback forms

Reminder: Information and timelines are current as of the date of the presentation

What is MCTAC?

MCTAC is a training, consultation, and educational resource center that offers resources to *all mental health and substance use disorder providers in New York State*.

MCTAC's Goal

Provide training and intensive support on quality improvement strategies, including business, organizational and clinical practices to achieve the overall goal of preparing and assisting providers with the transition to Medicaid Managed Care.



McSILVER INSTITUTE
FOR POVERTY POLICY AND RESEARCH



The National Center on
Addiction and Substance Abuse

CTAC & MCTAC Partners



People Get Better With Us



Small Business Initiative Partners



What is the Small Business Initiative?

Goal:

- To assess, inform and educate providers who have little or no experience billing Medicaid on the essentials necessary for Managed Care readiness.
- This training is provided by MCTAC and the SBI partners at ASAP, NYAPRS, The Coalition and Families Together.

For more information or with questions about the Small Business Initiative please contact Daniella Labate at daniellal@nyaprs.org.

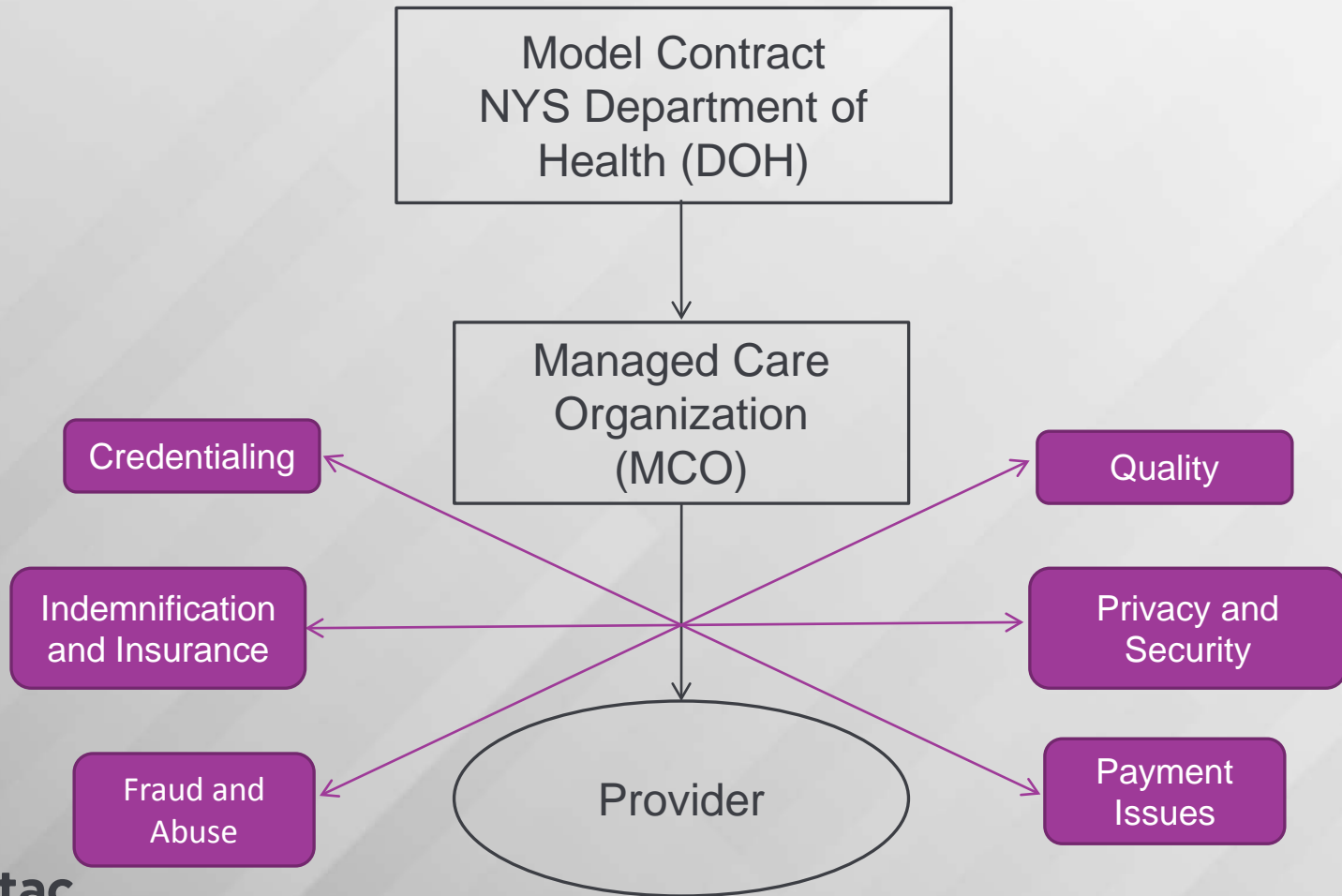
About our Presenter

For over the last decade, Whitney Magee Phelps, has focused her practice on state and federal regulatory health care issues, with an emphasis on managed care contracting, antitrust, fraud and abuse issues, health and medical homes, and joint venture arrangements. Her negotiations between and among managed care organizations, federally qualified health centers, IPAs, providers, pharmacy benefit managers and other management vendors include reviewing, drafting and handling all aspects of the negotiation process for both fee-for-service and full risk sharing arrangements. In addition, she has negotiated and drafted highly innovative and complex joint venture arrangements between managed long-term care providers and managed-care organizations. Whitney also has wide-ranging experience representing health care entities before the executive branch to shape health care policy, laws and regulations and to seek regulatory guidance for various joint provider and payer arrangements, such as for pay-for-performance and medical home demonstrations.

The Legal and Liability Issues for Providers in a Managed Care Environment

- The Legal Entity or Individual
- Credentialing
 - Licensure and Certification
 - Training
- Insurance and Indemnification
- Fraud and Abuse
- Quality Assurance and Standards
- Privacy and Security
- Payment Issues

Managed Care – The Contractual Relationships



The Provider

- ❑ Who is the provider legally responsible for the contract?
 - ❑ The Party
 - ❑ The legal entity(ies) entering into the contract
 - ❑ Performing Provider Systems (PPSs), IPAs, ACOs, professional corporation or a licensed provider entity
 - ❑ Multiple providers with different corporate entities but under a common parent
 - ❑ MCOs can only contract for the provision of services with licensed entities, professional corporations, IPAs or ACOs.

Credentialing

□ **Provider credentialing** is a systematic approach to the collection and verification of a **provider's** professional qualifications

Each MCO has its own credentialing process, which includes credentialing of the entity and of the individually licensed physicians and practitioners

Participation in a MCO's network as a participating provider is conditioned upon credentialing. Claims will not be processed until a provider is credentialed

MCOs are supposed to complete the credentialing process within 90 days of the submission of the application. The facility or program plays a crucial role in supplying information to the MCO about the individuals providing the services.

□ The qualifications that are reviewed and verified include relevant training, licensure, certification, and registration to practice in a health care field

Credentialing

- ❑ Credentialing is important for the following reasons:
 - ❑ To ensure quality of care for MCO members; and
 - ❑ To avoid potential malpractice liability. If (i) an MCO accepts a provider into its network, (ii) the provider causes patient harm and (iii) the provider should not have been included in the network based on information the MCO should have been aware of, then the MCO could be exposed to potential liability

Credentialing

- ❑ What does it mean to be a provider in an MCO's network?
 - ❑ Providers can anticipate a certain volume of business
 - ❑ Provider must agree to follow MCO policies and procedures
 - ❑ Providers must meet certain access requirements (Hours / Time / Distance / Cultural Competency)
 - ❑ Urgent Care Appointments – within 24 hours of request
 - ❑ Follow-up (after emergency or inpatient admission) with a mental health or substance abuse provider – within 5 days of request
 - ❑ Non-urgent mental health or substance abuse visit – within 2 weeks of request
 - ❑ MH/SUD assessment – within 10 days of request

Insurance and Indemnification

- MCOs will require providers to have malpractice insurance and general liability insurance and provide proof of insurance
- Notice must be provided if such coverage is not provided or MCO must be added as an additional insured
- Provider should understand its insurance limits and policy restrictions (Is contractual indemnification allowed?)
- Types of insurance
 - Malpractice
 - General liability
 - Cyber security

Insurance and Indemnification

- ❑ Indemnification and Liability
 - ❑ Contractual indemnification – mutuality
 - ❑ MCOs can't transfer liability for its own acts and omissions onto a medical group
 - ❑ Joint and several liability if contract is with multiple legal entities (i.e., PPS)

Fraud and Abuse

Definitions (42 CFR 455.2)

Fraud = “an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person”

Abuse = “provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary costs to the Medicaid program”

Fraud and Abuse

- ❑ MCOs are required to have in place a comprehensive fraud, waste and abuse detection and prevention plan and special investigation units
- ❑ Providers receiving reimbursement for Medicaid services (\$500,000 annually) must have a compliance program in place and annually certify
- ❑ Requirements under the Federal Deficit Reduction Act
 - ❑ Employee education regarding False Claims Act

Fraud and Abuse

- ❑ The Affordable Care Act (ACA) strengthened fraud and abuse prevention measures
- ❑ Section 6402(h) allows HHS to “**suspend payments to a provider of services or supplier**” while investigating a credible allegation of fraud
- ❑ New York issued regulations conforming to this provision of the ACA at 18 NYCRR 518.7

Fraud and Abuse

- ❑ “**Credible allegation**” is defined as “an allegation that has indicia of reliability and has been verified by [OMIG], or the Medicaid fraud control unit, or another state agency, or law enforcement organization”
- ❑ Can come from any source
 - ❑ Fraud hotline
 - ❑ Claims data mining
 - ❑ MCOs
 - ❑ Patterns identified through audit

Fraud and Abuse

❑ The State

- ❑ “**MAY**” withhold payment when OMIG “has determined that a provider has abused the program or has committed an unacceptable practice”
- ❑ “**MUST**” withhold payments when “it has determined or has been notified that a provider is the subject of a pending investigation of a credible allegation of fraud unless the department finds good cause not to withhold payments”

Fraud and Abuse

- ❑ **OMIG has stated that:**

- ❑ Pursuant to federal guidance on this issue, the provisions of ACA which require a State to withhold payments to a provider who is the subject of a pending investigation of a credible allegation of fraud will apply to managed care network providers.
- ❑ Also applies to credible allegations of fraud against a Medicaid managed care plan or an MLTCP

Fraud and Abuse

In addition, under the ACA, Providers must report and return overpayments

If a person has received an overpayment, the person shall:

Notify, report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address and the reason for the overpayment; and

An Overpayment is any “funds” for which the person is not entitled (eligibility, conditions of payment, kickback)

Overpayments must be reported and returned within 60 days after the overpayment was identified

* The Importance of Documenting Services Provided

Privacy and Security

Privacy

Under HIPAA, protected health information (“PHI”) may not be used or disclosed without a written authorization from the subject to whom the PHI relates

There is an exception for sharing PHI between two covered entities (or a business associate on behalf of a covered entity) for purposes of:

Treatment

Payment

Health care operations

A covered entity is a provider (that submits electronic claims), MCOs and a health care clearing house

As such, information can go between providers for treatment purposes and between an MCO and provider for payment or treatment purposes

Privacy and Security

- ❑ However, the covered entity receiving the information must have a relationship with the subject of the PHI
 - ❑ Also, all permitted uses and disclosures of PHI must be limited to the “minimum necessary” to accomplish the intended purposes of the use, disclosure or request
 - ❑ This includes giving the information only to the employees in the organization who need to know the information

Privacy and Security

- NY law requires written consent, but such consent can be obtained at the time of enrollment or by the provider
- However, there are specific state provisions that govern the disclosure and confidentiality of the following records:
 - HIV records;
 - Mental health records;
 - Genetic information;
 - Alcohol and substance abuse (which generally defer to HIPAA); and
 - Other sensitive categories (minors)

New York Privacy Requirements that are more restrictive control

Privacy and Security

☐ Security

☐ Under HIPAA, a covered entity must maintain reasonable and appropriate administrative, technical and physical safeguards for protecting electronic protected health information (e-PHI). For example, can't send specific patient information via email unless through a secured server and must educate workforce about privacy protections

Privacy and Security

- ❑ Failure to adhere to privacy and security standards can result in:
 - ❑ Enforcement actions by the Office of Civil Rights, Dept. of Health and Human Services;
 - ❑ OCR responds to complaint investigations and security rule violations; and
 - ❑ Enforcement actions have begun

- ❑ A recent court case allowed the HIPAA privacy regulation to serve as the standard of care in a negligence action involving the release of medical records

Payment Issues

- ❑ Providers must submit claims timely or run the risk of not getting paid.
- ❑ The statutory minimum for Medicaid is for claims to be submitted within 90 days of the date of service or the date of discharge.
- ❑ However, a longer time period can be negotiated as agreed upon by the entities.

Providers should confirm that the contractually stated time period can be met.

- ❑ It is important to submit claims or encounter data because:
 - ❑ MCOs must submit encounter data 2xs/month or be subject to sanctions (\$2,000/day)
 - ❑ Provider contracts may impose financial penalties on the provider if the provider fails to submit required encounter data

Conclusion

- Important to provide truthful, accurate and complete information to the MCO
- Ensure the entity and all licensed professionals in the organization are credentialed by the MCO
- Document the services rendered accurately and completely
- Ensure services are documented in the Members Plan of Care before being rendered
- Only bill for services that are provided and documented
- Understand when patient information (records and data) can be shared
- Ensure the security of all electronic patient information

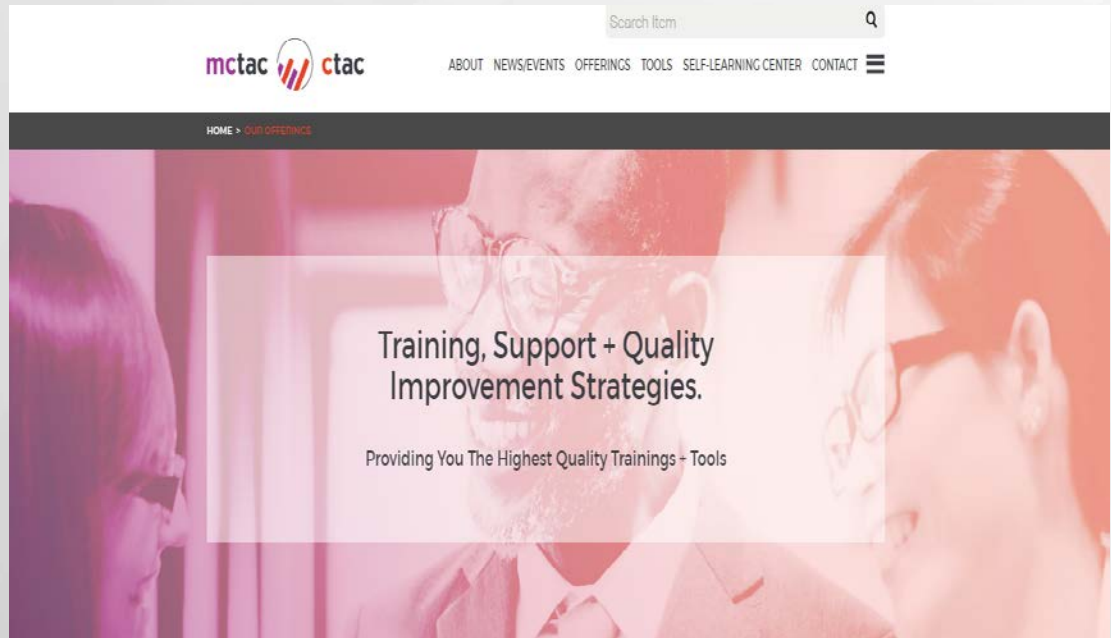
Questions and Discussion

Please send questions to:
mctac.info@nyu.edu

Logistical questions usually receive a response in 1 business day or less.

Longer & more complicated questions can take longer.

We appreciate your interest and patience!



Visit www.ctacny.org to view past trainings, sign-up for updates and event announcements, and access resources