How to Deal Effectively With Recent Legal Developments

November 10, 2017

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Agenda

- Legislative, Administrative and Regulatory Developments
  - Repeal/Replace/Reform/Remain
  - Regulatory and Enforcement Trends
  - Physician Relationships
  - Payer audits and statistical modeling
  - NPP Enrollment
  - Burgeoning Challenges for Compliance Professionals
  - Practical and Effective Approaches

Legislative and Administrative Developments
October 12, 2017 Executive Order

- De-fund premium subsidies to insurance companies (CSRs).
- Association health plans selling/purchasing insurance across state lines. See e.g., Sen. Rand Paul (R-KY).
- Note: Association health plans have been opposed in the past by many stakeholders, like governors, insurance commissioners, attorneys general because they could undermine a state’s ability to regulate its insurance market.
- Ex.: Healthy people → states that allow skinny/cheap plans disrupts market.

CHIP Program

- Program authorized through 2019, funding expired Oct. 1.
- Leeway because states won’t start running out of funding until December.
- Cancellation/freeze notices may have to be sent in October.
- States could shift funding around.
- Push to do separate funding, but could be coupled with more controversial items.
- Policy colleagues indicate delay until as late as December.

When CHIP Funds Run Out

<table>
<thead>
<tr>
<th>Quarter of Fiscal Year</th>
<th>Number of States</th>
</tr>
</thead>
<tbody>
<tr>
<td>First quarter (October-December 2019)</td>
<td>4</td>
</tr>
<tr>
<td>Second quarter (January-March 2019)</td>
<td>27</td>
</tr>
<tr>
<td>Third quarter (April-June 2019)</td>
<td>19</td>
</tr>
<tr>
<td>Fourth quarter (July-September 2019)</td>
<td>1</td>
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</tbody>
</table>

Note: CHIP is the Children’s Health Insurance Program. Source: The Urban-Brookings Tax Policy Center and Health InsuranceNTS. Data from the Centers for Medicare & Medicaid Services' states' Children's Health Insurance Program expenditures databases as of May 2017.
Mounting Challenges for Health Care Providers

- More pressure on Medicaid Programs, many of which are broken
- More state control
- MCOs with an inefficient state overlay
- More pressure on states → more pressure on Medicaid providers
- Instability of insurance markets
- Rising premiums, deductibles
- Fewer people insured → fiscal burdens on providers

Regulatory and Enforcement Trends

Physician Relationships – What We See

- Valuation firms tightening up
- Cookie cutter approaches
- Data disconnects
- Wrong data
- Invalid assumptions
- Lack of communication
- Side deals different from contract
- Practices become different from original assumptions
- Physician expectations set in advance of analysis
- No review of draft reports
- No separation of duties
Physician Relationships – What Not to Do

- Trust existing processes
- Trust what people are telling you
- Rely on old advice
- Fail to question evaluators and counsel
- Fail to document rationales
- Proceed without role definition
- Allow unfortunate email chains to propagate
- Involve too many stakeholders when there is an issue
- Go it alone – you need safety valves

Physician Relationships Best Practices

- Updated contracts
- Contracts signed
- Contracts tracked
- Consistent contracting standards
- Services well-defined
- Keep track of services
- Qualified and informed people running valuation process
- Meet with evaluators
- Develop data protocols
- Separation of duties
- Sign-offs by key stakeholders
- Curtail informal physician communications
- Maintain backup
- Watch unfortunate emails

NPP Enrollment

- Affordable Care Act requires APRN enrollment in Medicaid programs (42 CFR 455.410):
  The State Medicaid agency must require all ordering or referring physicians or other professionals providing services under a State plan or under a waiver of the plan to be enrolled as participating providers.
- Treating
- Ordering, prescribing, referring
- Consequences: Direct and third party claim denials, scripts not filled
Payor Audits and Statistical Modeling

Statistical Modeling Applications

- Payors and contractors use it.
- Providers use it.
- Government uses and accepts it.
- Courts generally uphold it to calculate FCA damages.
- Most courts also require additional, non-statistical evidence of liability (overpayments do not always mean fraud).
- Some courts have refused to allow sampling when the claims require highly unique determinations of medical necessity.

What is the General Statistical Modeling Process?

- Question to be answered
- Universe of claims to be examined
- Sampling protocol
- Statistical tolerances
- Review tool
- Probe sample
- Comprehensive sample
- Financial estimation ("Extrapolation")
Legal, Regulatory and Other Guidance

- CMS Program Integrity Manual ("PIM")
- Office of Inspector General/Office of Audit Reports
- CMS Program Memoranda
- GAO Reports
- Office of Inspector General’s Self-Disclosure Protocol
- Generally accepted statistical principles
- Federal court decisions
- ALJ decisions

Government Conventions

- RAT-STATS
- Probe Sample (30 or 50)
- Precision (10-25%)
- Confidence (90%)
- Lower Limit of Confidence Interval
- Mean Point Estimate
- Underpayments can offset (or not)
- 5% or lower overpayment, stop
- One size fits all

Designing Solid Statistical Modeling

- Key initial decisions impact future viability.
- Develop an entire plan before commencing.
- Use specialized statistician, reviewer, counsel.
- Generate an appropriate review tool.
- Timeline and accountability.
- Make sure every step is documented, mainstream, and replicable.
- Don’t vary from the playbook.
- Connect the dots: legal arguments and statistical findings.
What Should We Do?

Practical Approaches

- Double-up on Medicaid expertise, diligence.
- Address NPP roles, status, enrollment.
- Focus on physician relationships.
- Relationship with professionals who understand statistical modeling.
- Assessment as an infomercial.
- Leverage organizational resources.
- Thoughtful and achievable work plans.
- Get/stay in front of Senior Leaders and Board.

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