AHLA

VOLUME 12 ISSUE 1 March 2019

Business Law & Governance

A Publication of the American Health Lawyers Association
Business Law and Governance Practice Group

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Suing an Insurance Company to Enforce Coverage: What Every In-House Lawyer Needs to Know Before Pulling the Trigger

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Imagine the following scenario: a company has tendered a lawsuit to its liability insurance carrier under a duty-to-defend policy. The carrier won't settle, and the final pre-trial mediation approaches. Defense counsel advises that the policyholder is likely to lose at trial, possibly for an amount exceeding policy limits. Corporate counsel has written multiple settlement demands to the carrier. The adjuster refuses to pay plaintiff's demand, and offers less than the matter's settlement value. In a meeting to discuss mediation strategy, the company CEO and CFO ask corporate counsel if the carrier's basis for denying coverage is correct. Corporate counsel tells them that the insurer's position appears to be wrong. Angrily, they tell in-house counsel to sue the insurance company for bad faith.

How should corporate counsel respond to the client in this situation? Filing a bad faith action against a carrier is expensive and risk-intensive, and should be a last resort. When advising senior management whether and when to do this, corporate counsel must identify and execute the steps that should be taken before filing suit to try to settle the case with insurer money. The following should be done to socialize the C suite about this nightmare scenario, and put maximum pressure on the carrier to settle the pending lawsuit before pulling the trigger and suing the insurance company for bad faith.

First, define objectives. The primary objective is to protect the company from an excess-of-limits judgment by achieving an insurance-funded settlement. But there is an equally important secondary objective: To inoculate senior management to the possibility that all or part of a judgment may not be covered, or that the judgment may be for a number greater than the policy limits. If the lawsuit presents either possibility, corporate counsel should prepare the client for this up front.

To do this, corporate counsel needs to understand the merits of the company's insurance claim. Unless the in-house lawyer has insurance expertise, insurance recovery counsel should be engaged to assess the claim and recommend a settlement strategy. It is customary for the claim adjuster to commission outside counsel to write a coverage opinion upon receipt of a complex claim. When senior management asks the strength of the company's claim, corporate counsel must be in a position to make the same assessment. A coverage opinion, though not a guarantee of a particular outcome, is a useful planning tool to map a campaign against the carrier.

Second, exhaust back channels. Often it is impossible to tell whether the adjuster handling the claim is closely supervised by claim department managers. A junior adjuster may not have reported the carrier's exposure to her superiors. Ask the insurance broker to elevate the claim to management to give the carrier the chance to check the adjuster's work and fix mistakes. Also, ask the broker to leverage her relationships with the carrier's underwriters. If an argument can be made for claim payment, the broker should ask the underwriters to intervene with claims personnel, but corporate counsel should understand the broker's limitations.

When demanding that the adjuster change course and pay a claim, give the adjuster an opportunity to save face. When arguing that the carrier undervalues the litigation, identify game-changing facts that justify a position change. A last-minute expert deposition that goes wrong, an unfavorable motion *in limine* ruling, or the collapse of a key witness during trial preparation may change an adjuster's mind.

Third, if the insurer persists in its refusal to settle the underlying case, identify the three available options: (1) immediately file a bad faith suit against the carrier; (2) settle the case within policy limits to cap exposure, then pursue remedies against the carrier to recover the settlement; or (3) risk trying the case in hopes that the outcome is less than the carrier's last settlement offer.

While filing immediate suit against the carrier may force settlement, it often has the opposite effect. At many carriers, once bad faith litigation is filed, the matter is transferred for internal handling to another department with new decision-makers. The matter enters a new chapter in which civil procedure determines deadlines rather than reason, lessening any momentum toward settlement that may have accumulated. Ironically, filing suit immediately may give the carrier an excuse to ignore the critical situation confronting the policyholder.

Although an immediate lawsuit may empower senior management, this feeling may not last once attorney bills arrive. Ultimately, this option might not accomplish the objective of settling the underlying case with carrier money.

The second option is to pay the plaintiff and chase the insurer. Capping exposure is positive because it eliminates the possibility of the plaintiff winning a trial judgment exceeding policy limits. But the policyholder's senior management's expectations must be managed if this option is elected. In a lawsuit against the insurer, a corporate insured may recover damages in the amount of the unpaid claim and the attorneys' fees and costs incurred to recover it. In many states, the latter are not recoverable or only partly recoverable. Insurance companies rarely pay the policyholder's

attorneys' fees as part of a settlement of a bad faith case; instead, they pay them only when they lose at trial.

The same rationale applies to punitive damages. Absent highly unusual circumstances, insurers do not pay punitive damages as part of a settlement of bad faith litigation. Punitive damages are inherently unpredictable, and the carrier will not pay them unless it loses at trial and on appeal.

The carrier's objective in a bad faith action is to either win on coverage (which in most states eliminates the policyholder's bad faith cause of action) or settle the claim at a discount. If corporate counsel advises senior management to pay the plaintiff and chase the insurer, it should be understood that unless the company risks the expense of bad faith litigation and wins, the company is unlikely to recover the entire settlement amount it paid the underlying plaintiff.

The third option—braving trial and hoping for an outcome equal to or less than the carrier's original offer—is extremely risky where exposure exceeds policy limits. The carrier knows this, and may refuse settlement with the underlying plaintiff to pressure the corporate policyholder to contribute to the settlement to avoid this risk.

The policyholder can hedge this risk of an excess-of-limits outcome by deploying the Excess Judgment Rule (EJR), which is in effect in virtually all jurisdictions. The EJR provides that a carrier must settle if there is liability in excess of limits and an opportunity to settle within limits. If it breaches this duty, it is liable for an excess-of-limits outcome. To trigger the EJR, the insured must prove that (1) the facts and law showed, pre-trial, that liability exposure exceeded limits; (2) the carrier knew this; (3) the carrier had opportunity to settle within limits and did not take it; and (4) the carrier showed disregard or demonstrable indifference to the interests of the insured.

The EJR can be deployed before trial to pressure the adjuster to settle with the plaintiff. When used as a threat pre-trial, the EJR is a potent weapon. Payment to policyholders of excess-of-limits judgments is anathema to claims departments. Claims-handling software may not allow the setting of a reserve in excess of limits. Reinsurers may not pay excess judgments. Adjusters know that when a carrier must pay more than limits, someone is fired. If the EJR prerequisites line up, the adjuster may decide that it better serves his or her to settle the case and pay the plaintiff.

In the event of a catastrophic trial judgment, the EJR becomes the focal point of a new, urgent round of settlement negotiations. The policyholder never wants to be in this position. If the EJR is actually triggered rather than used as a pre-trial pressure point, a disastrous trial result has occurred and negotiations will be conducted with a gun pressed to the policyholder's temple. The carrier usually argues that it had no reason to think the plaintiff's case against the policyholder was worth more than policy limits. The best rebuttal is that the carrier's business is to evaluate liability, and the excess-of-limits verdict is the best evidence that the insurer evaluated incorrectly. However, no company wants to have a massive judgment entered against it in the public record. The EJR therefore is best used pre-trial as a way to pressure the carrier to settle with the plaintiff.

None of these three options for forcing a recalcitrant carrier to settle underlying litigation is ideal, and each carries expense and risk. If corporate counsel socializes the policyholder's senior management to these expenses and risks, they can proceed with open eyes. If a company decides to sue the insurer for bad faith, corporate counsel will launch this initiative confident that she has first exhausted every alternative. If the policyholder has done its homework, it will go into the fray with a solid recovery strategy in place.

Chair's Column

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Welcome to the latest edition of the Business Law and Governance Practice Group's (BLG PG's) newsletter. I am delighted to introduce to you an edition of particularly diverse topics. We thank you for reading.

Nearly all organizations have some insurance coverage to cover a variety of possible situations, including when the organization is facing a lawsuit. But what does an organization do when a carrier attempts to deny coverage? David Wood and Kelsey Dilday review options and strategies for organizations facing such a dilemma and how to engage with the carrier.

There has been a greater acceptance and use by organizations of enterprise risk management. Sharon Blackwood and Kelly Nueske outline how enterprise risk areas should be reported to an organization's governing board.

Finally, Stephen Bittinger takes us into the always dynamic world of payer/provider relations. However, Stephen brings a twist to the discussion by examining an audit done by the U.S. Department of Veterans Affairs.

We are in the middle of another great year for the BLG PG. From free educational calls on cutting-edge topics, to practical tips provided by presenters on our webinars, to in-depth discussions in our publications, our volunteers have continued to work very hard this year to respond to our members' requests about what they want.

What would you like more of from us? We are eager to hear from you on topics and do our best to serve you.

Publications?
Contact our Vice Chair of Publications, John Garver, at jgarver@robinsonbradshaw.com.

Webinars or educational calls?
Please reach out to our Vice Chair of Educational Programs, David Weil, at David_Weil@QuorumHealth.com.

Alerts or bulletins?
Send an email to our Vice Chair of Research and Website, Judy Mayer, at mayerj@ihn.org.

You can always feel free to contact me as well about anything BLG PG-related at gprives@mdmc-law.com or call me at (973) 425-4179.

I would like to conclude by thanking our authors for their contributions, the wonderful AHLA staff for all of their hard work, and, most importantly, our editors, John Garver and Stacey Callaghan.

Best wishes,

Glenn P. Prives
BLG PG Chair, 2018-2019

Reporting Enterprise Risk Areas to the Board

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Enterprise risk management (ERM) is now an accepted and common system-wide, integrated approach to addressing an organization's internal and external risks. The underlying concept of ERM emerged in financial institutions to measure, prioritize, and manage risk associated with market changes and volatility. Because of the universal applicability, it quickly spread to other industries like health care. This article will explore how ERM activities should be reported to the entity's board.

One role the Board of Directors play is that of risk oversight. The Board needs to understand existing risks, how risks are managed, and emerging risks as a part of their fiduciary responsibility. This responsibility includes due diligence and therefore the Board should have a thorough understanding of the organization's risks and should be approving the overall ERM strategy.

ERM in Health Care Basics

Change is constant in health care, evidenced by continued mergers, acquisitions, and realignments. As health care delivery models continue to evolve, Board members and leaders must be willing to appropriately embrace entrepreneurial risk and pursue risk-bearing strategies. Technology, reimbursement models, regulatory pressures, customer preferences, competitor product offerings, and labor markets force organizations to be innovative and create new sources of value for their customers so they can compete in the marketplace. Like change, risk management is fluid. The perception and management of risk depends largely on the organization's strategy and risk appetite. And, as discussed below, the board's views on these points will inform the reporting it requires on ERM issues.

ERM is a proactive process for looking across the organization with a broad lens and identifying areas where due diligence is prudent, looking at opportunities, positive and negative effects, and applying effective strategies at the executive level for managing the organization's exposure. An ERM program can provide the Board with the support it needs to manage uncertainty and focus on the issues critical for successful governance. Boards that understand the ERM framework and associated concepts will be better able to benefit from applying ERM to risk oversight.

Organizational Risk Assessments

In April 2015, Department of Health and Human Services Office of Inspector General (HHS OIG), the American Health Lawyers Association, the Association of Healthcare Internal Auditors, and the Health Care Compliance Association released a collaborative educational resource—*Practical Guidance for Health Care Governing Boards on Compliance Oversight* (Guidance for Boards)—to assist governing boards of health care organizations carry out their compliance plan oversight obligations.[1] The publication states that compliance is an enterprise-wide responsibility and highlights the complementary roles of the internal audit, compliance, and legal functions in any comprehensive compliance program. Likewise, the Guidance for Boards states the Board should ensure that management and the Board have strong processes for identifying risk areas and lists potential areas of audit to include referral relationships and arrangements, billing, privacy breaches, and quality-related events. These are the same concepts as ERM.

An effective ERM program is a collaborative approach to analyzing multiple risks "across the enterprise" and elevating the risk management team as a strategic partner in achieving corporate goals and objectives. Often, there are several departments performing some sort of risk assessment, either annually or ongoing, for example:

a. *Risk Management Department* uses incident reports and grievance information (typically ongoing) to analyze trends and risks. Health care risk management has traditionally focused on insurance and litigation associated with liability and hazard coverage programs—"protection from loss" in insurable categories, such as medical malpractice, general liability, property loss, and directors' and officers' risk. In some organizations, Risk Management has evolved to include clinical risks e.g., medication errors, hospital-acquired conditions, and serious safety events. These programs have traditionally relied on reported events and incidents to identify risk, so their activities tended to be reactive and retrospective.

b. *Quality Management Department* performs analysis and projects to identify clinical care risks (typically ongoing). The Centers for Medicare & Medicaid Services' (CMS') Center for Clinical Standards & Quality initiatives focus on publicly reporting quality measures for nursing homes, home health agencies, hospitals, and kidney dialysis facilities. This includes Merit-based Incentive Payment System (MIPS) for eligible professionals, sunsets payment adjustments under the current Physician Quality Reporting System, the Value-Based Payment Modifier, and the Medicare Electronic Health Records Incentive Program, often referred to as the Meaningful Use program, and consolidates aspects of those programs into the new MIPS.

c. *Compliance Department* often uses the OIG annual workplan, surveys, or other forms of data collection methods (annually) to develop a risk-based work plan. Compliance risk is defined as the risk of legal or regulatory sanctions, financial loss, or damage to reputation resulting from failure to comply with laws, regulations, rules, other regulatory requirements, such as the Health Insurance Potability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act, the Emergency Medical Treatment and Labor Act, billing and coding, and Stark and Anti-Kickback, etc. Issues gleaned from the OIG Work Plan, recently established Corporate Integrity Agreements, Office for Civil Rights activities and audit protocols, government enforcement trends, current CMS contractor and payer audits, and concerns from leaders based upon the knowledge of the care delivered within the facility are typically integrated into the analysis.

d. *Information Technology Department* takes responsibility for the security risk assessment which is part of the administrative safeguard requirement within the HIPAA regulations. Covered entities need to evaluate the likelihood and impact of potential risks to electronic protected health information, implement appropriate security measure to address those risk areas, and document their security measures, according to HHS. Overall, there must be "continuous, reasonable, and appropriate" security protections.

e. *Internal Audit Department* performs risk assessments, most often annually, to develop a workplan. Typically, the risk assessment focuses on the following risk domains: financial, information technology, operational, legal/regulatory, human capital, strategic, and hazards/business interruption. The process may be or could be the most comprehensive risk assessment in the organization.

Implementing an ERM program is not an easy task and its success depends heavily on governance and management support, organizational collaboration, thoughtful planning, and dedication. A successful ERM program must have a senior manager leading and dedicated to the execution of the program because there are so many departments assessing risk and often not collaborating. The program needs to have the following elements (TARP) to cover the risk plan:

- Transparency – a clear understanding of the entity's risk.
- Alignment with the strategy and risk appetite.
- Resources to manage the risk.
- Prioritization of risks into an ERM audit work plan.

After an ERM program is implemented, the Board should watch for challenges such as:

- The enterprise-wide focus shifts to one or two areas that get more attention.
- Projects are managed inappropriately, so high priority risks are not assessed or mitigated.
- Distractions are allowed, causing the ERM program to be too fluid.

Reporting Risk to the Board

How to report and how much to report to the Board in large part depends on the frequency of the Board or Board committee meetings, how much time is allotted on the agenda, and how inquisitive the Directors are. One common challenge is management's failure to have a clear understanding of the Board's expectations. The Board Chair and/or Committee chairs need to communicate risk reporting expectations and provide suggestions on how the information should be shared. Another challenge may be the Directors' lack of health care knowledge or emerging trends, which may be the case with new Directors.

When evaluating the organization's strategic framework and risk environment, management should focus on areas that have the biggest impact to the well-being of the organization. While organizational committees and senior management require more details about identified risks and potential mitigation to take ownership, Boards and Board committees need the "right" amount of information to fulfill their fiduciary responsibilities related to risk oversight. Reporting the "right" risk information can be tricky and needs to prioritize key risks and management's assessment of the risk. The report would also include what risks are known and accepted as a risk without active mitigation. The Board report may be 10 – 15 pages to fully communicate the process and enterprise risks; however, the presentation should be tailored back to summarize the detail. The following are some reporting strategies to consider.

Use the Work Plan as a Threshold

Annually, the Board/Board committee should be given a work plan that outlines the external and internal impacts posing risks, an explanation of the risk prioritization and timeframes for accomplishing the tasks. The workplan should be used to track and report progress to the Board/Board committee at each meeting or at least semi-annually. Any deviations from the workplan timeframes should have an action plan and risk level.

Snapshots – Graphs, Pie Charts, and Graphics that Tell a Story

Data can be reported in a myriad of dashboards and snapshots but, in order to effectively communicate progress, metrics should be reported in comparison to industry benchmarks and best practices, if possible. Compared to narrative summaries, snapshot illustrations typically communicate status more easily and require less time to digest the data. In addition, a database system that will allow the user to capture criteria that communicates ongoing work should be used. Another common method used to prioritize risks is a heat map that illustrates risks on 2 axes—likelihood of occurrence and impact to the organization. Heat maps provide a quick visual of all risks and which risks have the greatest impact if not mitigated.

Top Ten List

Knowing there are several departments conducting ongoing or annual risk assessments, with each having a different focus, this information should be compiled and reported at least semi-annually to the Board/Board committee. Each department will more than likely have different tools and methods for tracking and measuring risks, which can create reporting challenges. One reporting method could be to have each department provide an update on the top three to five risks that are being mitigated or need prioritization. Ideally the format is consistent and in one document. Leaders from each of the departments should collaborate to create a common and effective reporting summary.

Conclusion

Effective risk oversight is the foundation of prudent organizational decision making and governance. The Board plays a critical role by communicating expectations to senior management and providing necessary oversight as a part of their fiduciary responsibility. As a Board or Committee chair, the Director should discuss with management reporting expectations and suggest the format in which a large amount of data should be presented at meetings. At a minimum, Directors need a well-documented report, at least annually, of how the risk program is executed and periodic updates on the overall program. Periodic updates should include the enterprise risk map, top 10 risks, emerging risks, and any trade offs made operationally to address high priority risks. Ongoing reporting and illustrating risk mitigation progress should be the focus of Board reporting.

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1 HHS OIG Practical Guidance for Health Care Governing Boards on Compliance Oversight, https://oig.hhs.gov/newsroom/news-releases/2015/guidance-release2015.asp.

An Extreme Example of the Importance of Payer Contracting

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Too often providers mistakenly assume that if payers are regularly reimbursing them for billed services, then nothing is wrong. As a health care reimbursement attorney that has represented providers across the country in disputes with payers, I thought most every basis for a conflict in the provider/payer relationship had come across my desk. However, when the Department of Veterans Affairs (VA) contracted with CGI Federal, Inc. (CGI) for Recovery Audit Contractor (RAC) services and began auditing in late 2017, a powerful example of why payer contracting is so important unfolded.

The VA's J-Code Audit

The VA has statutory authority to obtain medical services for veterans from non-VA care (NVC) providers when the VA is unable to feasibly provide care at one of its VA medical facilities (Community Care).[1] For Community Care,[2] VA representatives authorize such care by sending to NVC providers a VA Form 10-7079, *Request for Outpatient Services* or VA Form 10-7078, *Authorization and Invoice for Medical and Hospital Services* (collectively, Individual Authorization).[3] The VA pays for services obtained from NVC providers via Individual Authorization in accordance with payment methodologies described in 38 C.F.R. § 17.56.[4] NVC providers have provided care to veterans by Individual Authorizations for decades with little to no substantial change in procedure or development in regulation.

However, in October 2014, the VA Office of the Inspector General (OIG) received an allegation that the Veterans Health Administration's (VHA's) Florida claims processing centers had been overpaying an NVC provider for physician services.[5] VA OIG conducted a review of claims related to the October 2014 allegation,[6] as well as all VA payments for physician-administered drugs made by Florida VA facilities from October 1, 2012 through March 31, 2016.[7]

The VA OIG issued a report on June 5, 2017 that concluded Florida VA facilities overpaid NVC providers by about $17.2 million, and VHA's failure to utilize Medicare payment rates for physician-administered drugs (CPT codes that began with J – "J-Codes"), in accordance with the payment methodologies outlined in 38 C.F.R. § 17.56, caused the overpayments.[8] It was discovered that when the VA centralized claims processing from the facilities to the main offices of the VA in 2011, someone failed to load the reimbursement schedule for J-Codes, which caused all Individual Authorization drug claims to be overpaid up through 2017.[9]

Prior to the issuance of the June 5, 2017 report, to reduce the amount and number of overpayments, the VA awarded a recovery audit contract to CGI in January 2017.[10] The VHA Office of Community Care requested CGI prioritize J-code reviews. The VA intended for CGI to conduct the audit in accordance with and to fulfill the requirements of 38 U.S.C. 1703(d)(1).[11] The VA interpreted the statute's requirements to mean CGI must audit NVC obtained via Individual Authorization. Once CGI started sending out overpayment demands to NVC providers requesting the providers refund to the VA money the VA paid for physician-administered drugs in excess of Medicare payment rates, affected NVC providers started reaching out to legal counsel to discuss possible remedies.

Determining the NVC Provider Relationship with the VA

Unlike most all provider/payer relationships, none of these NVC providers had enrolled in a VA program or signed a contract with VA. Rather, the VA had simply initiated the relationship by calling the providers, asking them if they would treat veterans under

an Individual Authorization, and sending the providers patients upon oral approval. The problem is that Individual Authorizations are nothing like typical participating provider agreements or federal enrollments.[12] Individual Authorizations are ill-defined statutorily, and regulatory guidance provides no clear remedy to VA's CGI-contracted recovery audit. Moreover, Individual Authorizations are expressly outside the scope of contracted care, as defined by VA regulations, and more akin to the legal equivalent of a purchase order.[13]

Notably absent from Individual Authorizations were standard payer clauses,[14] which would have specifically defined the duties, rights, and remedies available to NVC providers should a dispute arise between the VA and an NVC provider. Examination of some of the industry standard provisions in a payer/provider relationship highlights this exacerbated scenario.

Claims Adjudication Duties

Take the typical "Claims Adjudication" provision in a participating provider agreement or Medicare regulation for example. These terms or regulations provide payer duties for timely adjudication, accurate adjudication, and other responsibilities of the payer that the provider may rely on should there be a dispute over whether the payer properly paid the provider. In the J-Code audit, there was no assertion by CGI that the NVC providers performed unnecessary services or improperly billed the services; the VA itself erred in a typical payer duty to properly adjudicate the amount to be reimbursed for properly performed services. Unfortunately, the void of allocation of proper adjudication responsibilities was not filled by the regulatory formula for reimbursement either,[15] and NVC providers were left searching for whether there was something more they should have done to prevent the overpayments.

Complaints and Appeals

The normal payer/provider participating provider agreement or regulation provides a "Complaints and Appeals" process. In the private payer arena, there is a customary contractual appeal process for overpayment determinations and the right to participate in some form of dispute resolution process should the appeal not provide the relief sought. Additionally, if a private payer resolution process does not resolve an issue, a provider can file suit under state law after fulfilling their contractual duties. Federal payers, such as Medicare, have well-defined processes to seek relief of overpayments that are eventually appealable to federal court.[16]

The dilemma for NVC providers under the CGI audit was that VA regulations failed to expressly address within its regulations provider complaints, appeals, or continuity of care for Community Care provided under an Individual Authorization. While there is a regulatory framework for contracted care, Individual Authorizations are expressly outside of this regulatory framework.[17] Also, care performed under an Individual Authorization was clearly not within the VA VHA Veterans Choice Program Provider Agreement (the Choice Provider Agreement),[18] because these NVC providers had never executed a provider agreement under Section 101 of the Veterans Access, Choice, and Accountability Act of 2014 (the Act) (Public Law 113-146, 128 Stat. 1754), as amended, and 38 C.F.R. §§ 17.1500-1540.[19]

NVC providers were left with examining a myriad of potential legal bases for asserting litigation as a starting point for relief.

Choice of Law

Even though most providers may not be able to negotiate a choice of law provision in a participating provider agreement or must acquiesce to federal law, these provisions at least provide direction for the legal framework for the authority under which the relationship and disputes may be resolved. Prior to contracting or enrolling, providers have the opportunity to educate themselves on whether or not they desire to submit themselves to the terms of authority in the relationship.

For NVC providers that had been sent overpayment demands by CGI, they were left to speculate on whether the Board of Veterans' Appeals (the Board) was a possible route for remedy as the Board's express authority was over all "questions of law and fact necessary to a decision by the Secretary of Veterans Affairs under a law that affects the provision of benefits by the Secretary to veterans or their dependents or survivors are subject to review on appeal to the Secretary."[20] While the Board has specifically indicated that disputes regarding "overpayments" are within the jurisdiction of the Board,[21] "the term overpayment refers only to those benefit payments made to a designated living payee or beneficiary in excess of the amount due or to which such payee or beneficiary is entitled."[22] This implied that an NVC provider is outside the Board's legal authority and NVC providers are left without true contractual, statutory, or regulatory guidance as to what remedies are truly available for them.

Audits and Investigations

Whether in a private payer relationship or under federal regulation, a provider has rights to hold auditors and investigators from the payers, or their agents performing the work, to standards regarding timeframes, how audits will be performed, education that auditors/payers must provide, and corrective action that may be taken to alleviate the audit.

Here, CGI was performing the Recovery Audit Contractors (RAC) audit under 38 U.S.C. 1703(d)(1) and 31 U.S.C. 3321,[23] which only provided that the RAC be conducted by contract,[24] that the VA could authorize CGI to notify NVC providers of potential overpayments, that CGI could respond to NVC providers' questions about possible overpayments, and that CGI could take other administrative actions concerning overpayment claims made or to be made by VA.[25] CGI had no authority, however, "to make final determinations relating to whether any overpayment occurred and whether to compromise, settle, or terminate overpayment claims."[26]

Prior to CGI sending to NVC providers overpayment notification letters, NVC providers that treated patients via Individual Authorizations would have been unaware of their rights and responsibilities as it relates to VA-directed audits and investigations, unaware of any

timetables to be imposed, and unaware of the method and scope of an audit. Individual Authorizations did not even have the words "audit" or "investigation" written on the face of the document.

Continuation of Care

Regardless of whether a payer and provider expect their relationship to continue in perpetuity, relationships sometimes sour, and patients' treatment needs to survive the termination of the relationship. Accordingly, private payers normally include in their contracts "continuity of care" provisions that address this very issue by expressly describing how patient care is to continue following the termination of the relationship between the provider and payer.

In the midst of the J-Code audit, several NVC providers considered whether they should terminate their relationship with VA as a result of the audit. The NVC providers, however, were uncertain as to how to transition care and whether veterans would be able to continue their episodes of care with the NVC providers because care provided under Individual Authorization expressly did not fall under other Community Care options. A single added clause on the Individual Authorization would have helped to dispel this uncertainty and ensure continuation of care for veterans.

The J-Code Audit Today

During the pendency of the audit, after recouping approximately $36 million in overpayments, the VA ceased the Community Care J-Code audit and suspended debt collections through CGI on October 29, 2018.[27] The VA has not yet announced whether it plans to resume the audit using agency resources, cease collections altogether, or resume recouping from NVC providers the overpayments for which VA has openly admitted responsibility.[28] All the uncertainty, financial exposure, and risk could have been eliminated by a basic framework of this relationship.

Conclusion

Although most providers believe the only value of having legal counsel review payers' contracts is to determine whether reimbursement rates can be negotiated with the payer, the VA's J-Code audit clearly demonstrates the extreme importance of understanding the nature of the provider/payer relationship, whether contractual, statutory, or otherwise.[29]

Stephen Bittinger *has a unique, national practice focused on health care reimbursement defense and litigation. Mr. Bittinger has represented numerous types of physician practices, home health agencies, medical facilities, ancillary service providers, medical laboratories, revenue cycle management companies, and drug/device manufacturers in Medicare audits (RAC, ZPIC, UPIC, TPE), Medicaid audits (AG), private payer audits (SIU), federal and state regulatory termination and exclusion proceedings, OIG exclusion and reinstatement proceedings, False Claims Act defense, and litigation related to the health care revenue cycle. Mr. Bittinger also serves as an expert witness on Medicare reimbursement and regulatory matters.*

1 38 U.S.C. § 1703(a).
2 *See* 38 C.F.R. § 17.52(a).
3 Veterans Health Admin., *Working with the Veterans Health Administration: A Guide for Providers*, Dep't of Veterans Affairs 3 (Oct. 2014), https://www.va.gov/communitycare/docs/pubfiles/programguides/nvc_providers_guide.pdf.
4 "VA pays for fee basis outpatient care using a hierarchy described in the CFR. The hierarchy requires that payments must first be made at a contract rate if a contract is in place. If there is no contract, VA pays using the CMS Participating Physician Fee Schedule rate. If there is no amount assigned by CMS for a procedure, then VA must pay either the lesser of the actual amount billed or the amount calculated using the '75th Percentile' methodology as provided in Title 38, Subsection 17.56(c) of the CFR. The 75th Percentile calculated amount is known as the VA Fee Schedule." Dep't of Veterans Affairs Office of Inspector Gen., *Audit of Allegations Regarding Payments for Fee Basis Care in Veterans Integrated Service Network 2* 1 (Mar. 21, 2006), https://www.va.gov/oig/52/reports/2006/VAOIG-05-03037-107.pdf.
5 Dep't of Veterans Affairs Office of Inspector Gen., *Review of Alleged Overpayments for Non-VA Care Made by Florida VA Facilities 2* (June 5, 2017), https://www.va.gov/oig/pubs/VAOIG-15-01080-208.pdf [hereinafter *Overpayments*].
6 *Id.* at 1.
7 *Id.* at 2.
8 *Id.*
9 Veterans Health Admin Office of Cmty. Care, *Audit Contract for Recovery of Community Care Overpayments*, Dep't of Veterans Affairs (Feb. 28, 2018), https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/FactSheet_20-11.pdf [hereinafter *Fact Sheet*].
10 *Id.*; CGI Group Inc., *U.S. Department of Veterans Affairs selects CGI for Community Care recovery audit services*, PR Newswire (Jan. 30, 2017, 7:30 AM), https://www.prnewswire.com/news-releases/us-department-of-veterans-affairs-selects-cgi-for-community-care-recovery-audit-services-612144923.html.
11 *Fact Sheet*, *supra* note 9.
12 *See DaVita, Inc. v. United States*, 110 Fed. Cl. 71, 80 (2013) ("The statutory and regulatory framework governing the provision of medical services to veterans establishes that the authorizations at issue are not contracts. Rather, authorizations are separate instruments to be used when a particular medical service is not available under an existing contract.").
13 *Id.*
14 *Request for Outpatient Services*, Dep't of Veterans Affairs, https://www.vendorportal.ecms.va.gov/FBODocumentServer/DocumentServer.aspx?DocumentId=485362&FileName=VA791-12-R-0009-007.DOCX.
15 *Overpayments*, *supra* note 5, at 2.
16 *See* 42 U.S.C. §§ 1395ff, 1395gg.
17 *See Davita*, *supra* note 12.
18 38 C.F.R. §§ 17.132 - 17.133, and 38 C.F.R. Parts 19 and 20.
19 Veterans Health Admin., *Veterans Choice Program Provider Agreement*, Dep't of Veterans Affairs 1 (Feb. 2016), https://www.va.gov/vaforms/medical/pdf/10-10145.pdf.
20 38 C.F.R. § 20.101.
21 38 C.F.R. § 20.101(a)(19); *see* 38 U.S.C. § 5302.
22 38 C.F.R. § 1.962.
23 Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, §2(h)(2)(C) 124 Stat. 2224, 2229 (2010) [hereinafter IPERA].
24 38 U.S.C. 1703(d)(1).
25 IPERA, *supra* note 23.
26 *Id.*
27 Veterans Health Admin Office of Cmty. Care, *VA to Cease Current Community Care Overpayment Recovery Audit*, Dep't of Veterans Affairs (Oct. 29, 2018, 10:38 AM), https://content.govdelivery.com/accounts/USVHA/bulletins/2166886.
28 *Fact Sheet*, *supra* note 9.
29 *Mem'l Hosp. v. Heckler*, 706 F.2d 1130, 1136 (11th Cir. 1983) (A provider/payer relationship could be based on contractual right or statutory entitlement.).

Resource Corner

Are You a Member of these Affinity Groups?

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New Toolkit!

Issues and Considerations in an Evolving Liability Environment: Summaries and Checklists Regarding Protections for Board of Directors and Executive Officers

This Toolkit identifies liability issues for directors and officers that organizations should be aware of and provides checklists of matters to consider with respect to managing challenges and risks.

Table of Contents:

- Background: Expanding Liability for Organizations and their Directors and Officers and The Impact of the Yates Memo
- Protections for Organizations and Their Directors and Officers: Indemnification and D&O Insurance and Director and Officer Concerns
- Checklists: D&O Insurance and Indemnification

Access this Toolkit at https://www.healthlawyers.org/Members/PracticeGroups/TaskForces/ERM/briefings/Pages/Issues_and_Considerations_in_an_Evolving_Liability_Environment.aspx.

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