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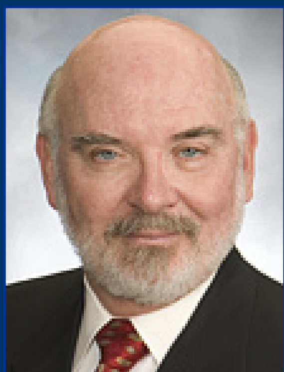

Bill Darling
600 Congress Avenue,
Suite 1600
Austin, Texas 78701
512.499.3685 Direct
bill.darling@strasburger.com

EDITORS
Kathy Darling
Brian G. Hamilton
Laura Reilly O'Hara

Health Care Providers Respond to Attempts to Set Quality Standards

Impact of Quality Initiatives

The health care quality initiatives recently developed by the Centers for Medicare & Medicaid Services (CMS) and other private payors require health care providers not only to provide quality health care services, but also to master a daunting new universe of quality-related programs. These programs have emerged as an outgrowth of the movement to reorganize the manner in which health care services are delivered and reimbursed, and they address items such as value-based purchasing, price transparency and public report cards.

This process has been slow as federal and state governments struggle with how to implement these changes. Furthermore, a natural reluctance exists for providers to expend time and money in preparing for program changes that may never come to be, depending on the change in national leadership that will occur following the 2008 election cycle. The trick for providers is to determine what steps should be taken now and what steps should be postponed until a clearer picture comes into focus with respect to the direction these program initiatives will take.

Few, if any, would quarrel with the need for the delivery in the United States of the highest quality health care possible. The difficulty is **defining** and **measuring** what "quality" means in the context of delivering health care services. Like so many other concepts in health care, quality is easy to promote, but not easy to quantify.

While it may be natural for health care providers to view the new value-based purchasing model with skepticism, CMS continues to move forward with the program unabated. It is not likely that value-based purchasing will be derailed regardless of who the next president of the United States may be. It is also important to note that other payors have started their own value-based initiatives instead of waiting to follow CMS' lead.

Provider Response to Quality Initiatives

Because of the difficulties in quantifying quality, health care providers are concerned that payors will define quality in ways that relate to cost and utilization rather than to tested and proven quality indicators. In September 2006, physicians in the state of Washington fought back after they were excluded from a physician network for Boeing employees by filing *Washington State Medical Association v. Regence BlueShield*. The plaintiff physicians allege that Regence announced that it was creating a "Select Network" that would include only those physicians who deliver "high quality, efficient care." By making such selections, the physicians claimed that Regence had violated the Washington State Consumer Protection Act, defamed the excluded physicians, intentionally interfered with the physicians' contracts and relationships, and breached the physicians' agreement with Regence. The lawsuit asked for injunctive relief in addition to monetary damages

In an aggressive move, Regence notified patients in a letter that their existing physician had been deselected from providing care in the Regence network as a result of a quality evaluation conducted by Regence. This notification letter stated that "(a)s a result of this evaluation, [your physician] will not be a network provider under the Select Network Plan." The physicians further alleged that Regence's decisions were "based on statistically flawed data and methodology that mischaracterized physicians' practices." Subsequent to the filing of the case, the American Medical Association joined the suit.

In December 2006, Regence decided to discontinue offering the Select Network Plan to Boeing employees. On August 8, 2007, the parties announced the settlement of the lawsuit. The settlement included an apology from Regence both to the excluded physicians and the patients in the Regence network because of its initial communication about the quality-based program. Regence made a contribution to the Washington State Medical Association (WSMA) Education and Research Foundation that works to educate providers about performance measure issues. Regence further agreed to include WSMA in the establishment of performance measures for future quality-based programs.

In an unrelated case, the Fairfield County Medical

Association (FCMA) has filed a lawsuit in Connecticut (*Fairfield County Med. Ass'n v. Cigna Corp.*). In this lawsuit, the plaintiffs include FCMA along with similarly situated physicians who claim that an "elite" physician designation awarded by Cigna, UnitedHealth Group, and Oxford Health Plans is harming their medical practices. The plaintiffs allege that cost is the sole determinative factor in the "elite" designation, and they are seeking designation as a class in order to pursue a remedy for all other physicians adversely affected. The allegations in the suit included defamation, tortious interference, breach of contract, unfair trade practices and conspiracy.

In addition to these lawsuits, the New York Attorney General has written letters to Aetna, Cigna and United Healthcare raising concerns about the accuracy of the rating systems they use to rate network physicians. The difficulty in implementing a fair rating system has become apparent in the disagreements that are surfacing.

The *Regence* case is an example of a successful challenge to a payor's program that apparently could not stand up to the challenge of a well-funded lawsuit. So what options are available to health care providers who are faced with the possibility of exclusion by a payor from an important provider panel?

1. Correct Erroneous Information

One of our clients relayed an alarming story that is instructive. This physician group practice comprises excellent surgeons but was denied a "quality" designation by an area health plan. When the group's administrator asked for information to explain why the group was denied the noted designation, his request was initially met with stonewalling. Only after persistent calls did the health plan advise the group that it would have otherwise received the "quality" designation but for one of the group's members that pulled their score below the minimum. This physician, however, was not a physician in the group. Since the "problem" physician was not in the group, it was relatively simple to correct the health plan's information. The group then achieved the "quality" designation.

2. Know Your Appeal Rights

Health plans that are NCQA-accredited have standards that include requirements for providers' rights. State insurance laws may also provide a health care provider with certain protections. If your organization or group is an existing provider within a plan network, check to see what contractual rights you may have for appeal of an adverse decision. Often, appeals are limited by strict deadlines. Failure to act timely may defeat your ability to preserve your rights.

3. Defend Against Defamation

A plan's decision to publish a list of "quality" providers and exclude certain providers or groups may create a negative financial outcomes as well as the inability to get into other quality panels. If the decision is based on incorrect information or a faulty methodology, the provider or group may have to consider taking legal action such as the WSMA did in the *Regence* case noted above. It is difficult to determine the reasons behind the settlement of the *Regence* case, but Regence's apology may signal that it was concerned about its liability for defamation.

Summary

It is clear that the initial reluctance of providers to sue payors for fear of retaliation has waned. In this period of flux, providers must carefully weigh their options in situations involving the new quality framework. Since there is no single way to address perceived injustices wrought by biased or faulty rating systems, providers must consider their options and make plans accordingly.

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