The Professional Liability Underwriting Society Hartford Chapter is pleased to present today’s educational event:

“Never Mind Healthcare Reform - What about Now? Executive Protection & Management/Professional Liability"

Date: Thursday December 6, 2012
Time: 2:00 – 4:30 PM (Registration begins at 1PM)
Location: Janet M. Blumberg Hall – 2nd floor of Hosmer Hall at the University of Connecticut School of Law, Hartford, CT

Overview: This educational symposium will feature a panel discussion to speak on the recent changes in the Healthcare landscape. The topics will include a discussion on Accountable Care Organizations, a relatively new Healthcare delivery model that seeks to control costs via accountability to patients and third party payers through specific quality metrics. Our other discussion points will be the Regulatory Enforcement and Anti-Trust Enforcement faced by Healthcare Companies.

Connecticut has approved this event for 2 General CE Credits.

PLUS Hartford Chapter thanks the University of Connecticut Insurance Law Center for their sponsorship of this important educational event.
Today’s Agenda:
Thursday December 6, 2012

Event Registration: 1:00 PM - 2:00 PM

Welcome and Logistics: 2:00 PM

Patricia McCoy Director, Insurance Law Center, University of Connecticut School of Law
Daniel Edwards, AVP Allied World Assurance Company Chairman, PLUS Hartford Chapter

Panel Presentations and Discussion:
Moderator: Andrew Charron, Allied World Assurance Company
Panelists: Anne Gouin, The Hartford
Neil Danaher, Danaher Lagnese, PC
Kevin Kelly, Medical Risk Management
Professor John Day, University of Connecticut

Break: 3:00 PM - 3:15 PM
Panel Presentations and Discussion Continued with Question and Answer Session

The Professional Liability Underwriting Society (PLUS) was established in 1986 as a non-profit association with membership open to anyone interested in the promotion and development of the professional liability industry. Our mission is to enhance the professionalism of our members through educational programs and seminars; to professionally address industry concerns with responsible positions and information campaigns; to assist our members endeavors to best serve clients; and to educate the public regarding professional liability.
Platinum Sponsors for Today’s Event

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On November 1, 2000, Connecticut Underwriters and its subsidiary companies, including CUIINCO (Connecticut Underwriters' premium finance company), were purchased by longtime employees William Kiley and Lillian Guilmartin.

Under this new ownership, Connecticut Underwriters continues to operate as it always has. Mr. Stone's philosophy of "No account is too small or too large" still holds true today.

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- Design Professionals
- Technology Firms
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Additionally, OneBeacon Professional Insurance provides employment practices liability insurance, management liability and tailored products for complex organizations including health care provider excess insurance and HMO reinsurance.
Biographies of Today’s Panelists

Andrew Charron: Allied World Assurance Company
As Vice President, Medical Products Manager, Andrew is responsible for the product development and best practices associated with the medical professional liability lines of business, including: hospitals, physicians, miscellaneous and clinical trials institutions. Andrew has 20 years of experience in the insurance industry, dedicated exclusively to the healthcare sector. His experiences include underwriting hospitals, physicians and miscellaneous medical risks at AIG, PHICO, GE Insurance Solutions (Medical Protective), and Darwin. Andrew obtained his B.S. Degree in business administration from the University of New Hampshire.

Neil Danaher: DanaherLagnese, PC.
Neil Danaher graduated from Georgetown University in 1969 and Georgetown University Law Center in 1973. He is a member of the Connecticut Bar, various United States Courts of Appeals and the United States Supreme Court. He holds a variety of memberships including the Hartford, Connecticut and American Bar Associations. Mr. Danaher is one of the founding principals of DanaherLagnese, P.C. Mr. Danaher’s practice has focused on complex litigation ranging from toxic material cases, pharmaceutical and medical device cases and medical malpractice cases. He has handled cases pending in numerous jurisdictions around the country. For over the past 15 years, a principal focus of his practice has been the defense of physicians, other medical providers and hospitals, including numerous trials. He lectures regularly in both Connecticut and out-of-state on issues related to proactive risk management measures regarding the delivery of medical care.

Kevin W. Kelly: Founder, President and CEO, Medical Risk Management
Mr. Kelly has been involved in both national and state healthcare policy development. His experience includes: founder and CEO of a regional managed care company, administrative positions in a large tertiary teaching hospital and university health center, Executive Director of a 500+ Physician Hospital Organization and a state health care regulator. Mr. Kelly maintains board and business advisory appointments at various organizations including nonprofit community organizations, pharmacogenomics, disease management companies, and large multi-specialty physician organizations. Mr. Kelly is a graduate of Yale University and Providence College.

Anne Gouin: Hartford Financial Products
Anne joined the Hartford in 2010 as a Director and Product Manager in the Hartford Financial Products segment of the organization’s Commercial Markets group. Anne is responsible for the creation, launch and ongoing management of the organization’s Healthcare Management Liability product line. Currently, she oversees underwriting strategy, integrity and direction for the healthcare market segment within HFP. Anne also has additional product management responsibilities within Middle Market Executive Liability at HFP.
Anne previously worked at Chubb, where she held a number of positions of increasing responsibility in the Health Care group, including Underwriting, Training and most recently Vice President and Zone Underwriting Manager for Chubb Specialty’s Healthcare business in the Wholesale and Northeast Retail markets. Prior to working for Chubb, Anne worked in large client sales and account management in Managed Care and Employee Benefits for several years, specializing in underwriting and managing customized and self-insured benefit and welfare programs. Anne is a member of PLUS and ASHRM, and a graduate of the University of Connecticut with a B.S. in Insurance.

John Day: Professor in Residence, University of Connecticut School of Law
Professor Day became Professor in Residence at the law school in 1999 after retiring from CIGNA Corporation, where he was Senior Vice President and Chief Counsel for insurance, healthcare benefits, pensions and investment law. Prior to joining CIGNA, he held a number of positions in federal and state government, private practice and academia. These activities included Assistant to the Vice Chairman of the Federal Power Commission, Special Counsel to the U.S. Secretary of Transportation, Deputy Superintendent of the New York Insurance Department, Insurance Commissioner for the Commonwealth of Virginia, of counsel with Steptoe & Johnson in Washington D.C. and Visiting Associate Professor at Osgoode Hall Law School in Toronto, Canada. He teaches Insurance Law, Health Care Financing and the Law, Business Organizations and the Regulation of Financial Intermediaries. He is a graduate of Oberlin College and Case-Western Reserve Law School.
Never Mind Healthcare Reform
What about now?

Panel Presentation/Discussion
12/6/2012
Thank you Hartford Chapter Annual Sponsors

Platinum
ROBINSON & COLE LLP

Gold

Silver

Connecticut Underwriters, Inc.
OneBeacon Professional Insurance®
Moderator:
Andrew Charron, VP Allied World Healthcare Product Lead – Moderator

Panelist:
John Day Professor in Residence  UCONN Law School

Kevin W. Kelly, Founder, President and CEO, Medical Risk Management

Neil Danaher, Esq. Danaher Lagnese, PC

Anne Gouin, Director, Product Management Hartford Financial Products
1. Introduction of Panelists – Andrew Charron
2. Outline of Presentations – Andrew Charron
3. Overview of ACA – Real or Incremental Change – John Day
4. Accountable Care Organizations – The New Frontier – Kevin Kelly
5. ACO’s – Potential for New Risks & Liabilities – Neil Danaher
6. Executive Liability for Healthcare Providers – Anne Gouin
7. Break
8. Open Panel Discussion – Questions and Comments
The Affordable Health Care Act: Real or Incremental Change?
Major Components of any Healthcare reform

- Access to quality care (affordability important)
- Cost to the system (a.k.a. % of GDP)
- Quality
- All interrelated
Grades for ACA

- Access – B+/A- (but much uncertainty on how people, employers and states will respond)
- Cost – D-
- Quality – C+/B- (generous/benefit of a doubt because of potential for evidence based medicine)
Access

• Mandates
• Market based regulation
• Exchanges
• Community based medicine
Cost and quality

- No global budget
- Patient centered outcomes research Institute (PCORI)
- Primary care emphasis
- Community Health Centers: expanded Federal Quality Health Plans (FQHP)
- Independent Payment Advisory Board (IPAB)
Open questions

• Will the mandates work?
• Will the Exchanges work?
• Will the states embrace the ACA’s expanded Medicaid program?
• Will the community based and wellness initiatives take hold?
• Will the focus on evidence-based medicine succeed?
• Can markets realize the goals of reform?
• Our attitude towards limits
Accountable Care Organizations (ACO)

The new frontier or more of the same...

Kevin Kelly
CEO
Medical Risk Management LLC
Emerging Market Factors Threaten status quo

**Rising Medical Costs**
August 2000-2010
- Healthcare Inflation Rate - 48%/CPI - 26%
- US Family Annual Healthcare Costs
  - 2002 = $9,235
  - 2011 = $19,393

**Strategic Positioning**
Hospital Mergers, Physician Practice Acquisitions by hospitals, larger med groups

**IT Systems/Electronic Health Records**
- Rapid and ubiquitous deployment of EHR
- Expensive and complex
- Asset or Liability?

**Quality Control & Reporting**
- Increasing demands for transparency from payers and consumers;
- expanding pay-for-performance programs;
- refusal by payers to pay for **never events**.

**Healthcare Reform**
- ACOs
- Medical Home
- Exchanges

**Impact on Healthcare System Players**
1. Move towards risk-based payments payments creating alignment conflicts between specialists and primary care
2. Reimbursement continues to be threatened
3. Pressures to increase patient throughput
4. Added administrative workload (HIPAA, documentation, risk management)
5. Application of clinical and business technology
6. Emerging PL and E&O exposures

**Physician Shortages**
The effect of a burgeoning physician shortage and its impact on compensation, recruiting and retention
1. FFS payment structure seen as a one root cause of fragmented, poor quality and low value care delivery.

2. Capitation and global payment schemes require a certain level of sophistication and integration

3. SHARED SAVINGS transition strategy
### The reality of volume to value - CT Large Medical Group

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Value Based Payment Opportunity

A New Definition of “High-Performance”

Question of Time, Not Direction

FFS payment trajectory

New Growth Potential

Value-Based Payment Models

Professional Revenue

Time
Physician Groups Adaptation to Changing Revenue Sources

More of the revenue is based upon quality bonuses and other incentives

<table>
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<tr>
<th>Introductory Phase</th>
<th>Transitional Phase</th>
<th>Evolved Phase</th>
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<tr>
<td>1. Majority of revenue coming from fee-for-service billing</td>
<td>1. Organization begins to supplement FFS revenues with incentive revenues</td>
<td>1. Global Capitation, PMPM payments</td>
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<td>2. Little need to address utilization and cost (broad referral network)</td>
<td>2. Activities that were once profitable have potential to negatively impact risk-based bonus payments</td>
<td>2. Narrow specialty networks</td>
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<td>3. “Every man for himself” mentality in FFS</td>
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<td>3. ALL providers accountable to the ACO</td>
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<td><strong>4. Population</strong> = patients who present at doctor's office</td>
<td></td>
<td><strong>4. Population</strong> = every patient in the provider organization panel, regardless of whether they present at the doctor's office</td>
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**Current Characteristics**

- Per procedure compensation models become problematic as organizations manage total cost of care
- ?? Incentives when group has one foot in each boat??
- Align economic rewards (risk-based) with reduced cost and improved quality for a defined population.

**Challenges to Comp Model**

1. FFS= more service-more $
2. P4P= more service less $

---

**Introductory Phase**

- Organization begins to supplement FFS revenues with incentive revenues

**Transitional Phase**

- Activities that were once profitable have potential to negatively impact risk-based bonus payments

**Evolved Phase**

- Global Capitation, PMPM payments
- Narrow specialty networks
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- **Population** = every patient in the provider organization panel, regardless of whether they present at the doctor's office

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**Challenges to Comp Model**

- Per procedure compensation models become problematic as organizations manage total cost of care
- Align economic rewards (risk-based) with reduced cost and improved quality for a defined population.
What is an ACO? Structures vary ...

1. Provider-led organization

2. Mission - for a defined population
   - Manage the full continuum of care
   - Accountable for the overall costs and quality of care.

3. Players include:
   - Primary care physicians (required)
   - Hospital(s),
   - Specialists and Other health care providers/facilities.
All care delivery is provided by the group

Services Medicare -
1. Administration
2. Informatics
3. Case Management
4. Disease Management
5. Specialty Networks

ACO Structure

Physician Organization PC

Ownership

Physician Organization ACO LLC

Payer Contracts

1. Informatics
2. Case Management
3. Disease Management
4. Specialty Networks

Providers Contracts

Hospital

MD Groups

Surgi Centers etc…

Aetna
UHC
BC/BS
Medicare
SHARED SAVINGS - Transition to Risk Share

Physician Organization PC

Ownership

Physician Organization ACO LLC

$ Shared Savings
Account Medicare

$ Shared Savings
Account Commercial Payers

Services Medicare-
1. Administration
2. Informatics
3. Case Management
4. Disease Management
5. Specialty Networks

PAYORS

ACO

Shared Savings
Account Commercial

Shared Savings
Account Medicare

Services Medicare-
1. Administration
2. Informatics
3. Case Management
4. Disease Management
5. Specialty Networks

ACO
Transformation: Major Areas

- Technology
- Care Coordination and Management
- Transforming the compensation model
- Building a culture
- Identifying:
  - Funding requirements
  - Partners
ACOs – A perceived plus to providers and patients – the reality includes potential increases in risks to providers

Neil Danaher, Esq.
Danaher Lagnese, PC
Are Providers Ready for the Risks Associated with Accountable Care Organizations?

Are accurate assessments being done to answer that question?
THE CONCEPT OF ACOs HAS BEEN ADVANCED, IN PART, BECAUSE OF AN EXPECTATION OF IMPROVED PATIENT CARE AND CONSEQUENTIAL REDUCED RISK.

IN ITS PUREST FORM, THE ACO MAY ACHIEVE THOSE GOALS.

HOWEVER, THE TRANSITION TO THE ACO & INCOMPLETE ACO STRUCTURES WILL ACTUALLY INCREASE THE RISKS.
The risks fall into two categories:

1) Increased traditional medical malpractice exposures.
2) Emerging or developing risks arising from the immature ACO.
Major areas of medico-legal concern

1. Establishing inadequate networks and systems of referrals within those networks.
2. Medical decisions driven by the goals of ACOs.
3. Incomplete or unclear protocols.
4. Managing the transition of care and information to/from the inpatient and outpatient settings.
   - Effectively
   - With attention to Health Insurance Portability and Accountability Act.
   - With attention to the Health Information Technology for Economic and Clinical Health Act.
Major areas of medico-legal concern

5. Hospitals/health systems not integrated with outpatient providers nor with unaffiliated community providers.

6. Exploitation and the vulnerabilities of the Electronic Health Record:
   - Flawed design and use.
   - Interface incompatibility – too little information.
   - Information overload.
   - Tracking and follow-up – The EHR is not yet the panacea.
   - The struggle of capturing meaningful use requirements vs. capturing critical clinical and medico-legal information.
   - Limited flexibility to modify order sets, processes or protocols based on clinical standards.
7. Administrative decisions will be subject to exposure.
8. Improperly created ACOs resulting in anti-trust and regulatory issues.
10. Insurance to cover the non-traditional risks.
ACOs are designed to manage patients’ care “across the continuum”, yet currently the transition of patient care from the inpatient to/from the outpatient setting remains a significant patient care, patient safety and medical malpractice risk area. Why?

- **Outpatient providers** are often unaware that their patients were even in the hospital – never receive a verbal, faxed or interfaced report.
- **Inpatient providers** almost always seek additional patient information from the outpatient providers.
The EHR becomes the key to the ACO effectiveness and risk mitigation

But there are problems...
Lack of integration of services

Although the practice of hospitals purchasing outpatient practices is on the rise, integration and coordination of services through perfected EHR (even within one institution) is not ideal.
Fully functional and interoperable EHR is central to:

- Safe and seamless transition of patients’ care.
- Population based tracking and quality improvement.

EHRs are *supposed* to expedite the exchange and improve the accessibility of:

- Key clinical data
- Providing discharge summaries
- Medication reconciliation
- Tracking status of transitions
- Identifying patients who transition between settings
Initial EHR Design v Patient Care

Initial Objective:

EHR Design

Areas Overlooked:
- Improved Quality of Care
- Reduced Medication Errors & Adverse Events
- Decreased Healthcare Costs


Unexpected Consequences

Errors
Inaccuracies
Oversights
Interface & System Incompatibility

Error

Disruption in Care

Suboptimal Outcomes

“Too Little Information”


Compatible & Incompatible systems: Information Overload

• Access to much more patient information through electronic means.

• If a provider has ACCESS to this information, a plaintiff’s attorney can argue that he should have REVIEWED all or most of it.

Adverse event  ➔  Claim: Breach of Standard of Care
Click many tabs to view different screens that comprise record.

Finding key, clinically relevant information can be difficult.

Difficulty sorting, sifting, locating information in chronological order. Concern over “hidden” information.
Failure to Follow-up Increases Risk

- Missed or Delayed Diagnoses
- Problems with Continuity of Care
- Poor Clinical Outcomes: Medicolegal risk
The public perception is that the EHR has the ability to automatically track and follow up on:

- Lab Tests
- Imaging Studies
- Preventative Screening Tests

Reality - EHR’s can track and follow-up but:

- System design for doing so is way behind the need.
- Multiple systems (interfaces) and methods of information exchange (e.g. paper faxed results) make it virtually impossible to use the EHR to consistently track and follow-up.
EHR systems are generally “canned” systems.
They are not designed to be modified or cannot be done so easily.
Therefore, these protocols (and system layout to support them) may not match current workflow.

**Issue:** Providers and staff implement “workarounds” to meet their needs resulting in increased patient safety and risk exposures.
Therefore, ACOs without solid and effective systems create multiple risks.
Over the past 10 years, dramatic efforts have been made to improve the medical malpractice climate in Connecticut.
Frequency of Connecticut Medical Malpractice Lawsuits - 1993-2011

24% reduction in claims since 2004

WHAT WILL THE INTRODUCTION OF ACOs DO TO THIS DYNAMIC?
Never Mind Reform, What about Now?

Executive Liability exposures for Healthcare Providers
Anne Gouin, Director, Product Management
Hartford Financial Products
December 6, 2012
Meet your Clients - Again

• **The Providers**
  – Meet my doctor and the hospital I was born at. They are also my clients. At least they haven’t changed. Or have they?

• **The Payors and their Members**
  – The journey from the Valley of Entitlement to the Jungle of network based healthcare and the Managed Care Pit Stop along the way.

• **The Perils**
  – I spent all that time learning Antitrust and Regulatory Fraud and Abuse to help my clients out of the Jungle and this new legislation comes along and changes it all?

  – *Maybe not as much as you think!*
# What’s really changed since the ACA?

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<th>Pre-Reform</th>
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<tr>
<td><strong>Providers</strong></td>
<td>Your doctors, Primary Care and Specialists</td>
<td>Physicians, nurses, care coordinators, ancillary providers, other advanced practitioners</td>
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<td><strong>Health care facilities</strong></td>
<td>Hospitals, the local one and the big one</td>
<td>Community hospitals, regional chains, for-profit hospitals, outpatient facilities and home care, ambulatory medicine</td>
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<td><strong>Payors</strong></td>
<td>Indemnity, discounted fee-for-service, preferred provider organizations and HMO’s</td>
<td>Network based care, mergers of regional managed care providers, consumer based care, ACO’s and cost sharing</td>
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<tr>
<td><strong>Participants</strong></td>
<td>Entitlement to participation in Medicare/Medicaid or an insurance program largely paid by an employer</td>
<td>More retirees, self employed and unemployed members are now participating in health plans with increased financial responsibility</td>
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<td><strong>Management Liability Exposures – the Biggest Three</strong></td>
<td>Peer review and credentialing, and institution focused antitrust and regulatory fraud and abuse enforcement</td>
<td>Provider selection claims, antitrust and regulatory fraud and abuse enforcement has expanded to include Outpatient organizations.</td>
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<td><strong>Management focus</strong></td>
<td>Mergers, growth, utilization management, managing costs through limitations.</td>
<td>Policy, compliance, financial management, consumerism and managing patient outcomes.</td>
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Peer Review and Credentialing

The highlights: The process of evaluating applicants for medical staff positions, traditionally those at hospitals and like facilities. Includes the process of granting privileges, as well as re-application, ongoing peer review of staff and the removal of medical staff for issues of competence or economics.

The exposure challenge: Prior to the late 1980’s, there was often a coverage gap between professional/general liability coverage and the directors’ and officers’ contract; the chasm created by the issue of negligence.

The response: Creation of industry specific directors’ and officers’ coverage for hospitals and healthcare systems to address allegations surrounding the peer review and credentialing process not originating from negligence and injury.
From Peer Review and Credentialing to Provider Selection

Provider Selection

**The highlights:** The peer review and credentialing process gone wild. Provider Selection is the expanded activity of evaluating applicants for medical staff positions in all practice settings, as well as healthcare providers presenting as individual entities or groups for participation in managed care and more recent delivery networks.

**The exposure:** In addition to the multi-faceted actions brought by individuals in the hospital setting, a denial of participation in a managed care or network setting can trigger a larger antitrust action as the denial can be perceived as a barrier to competition.

**The response:** Enhanced definitions within specific directors’ and officers’ coverage to address allegations surrounding the peer review and credentialing process not originating from negligence and injury, and accompanied by coverage for antitrust actions.
The highlights: Antitrust enforcement is focused on activities which substantially limit competition or create monopolies. In the context of the healthcare setting, may include exclusive contracts, denial of privileges or participation, perceived collusion among providers regarding rates, disproportionate market share through merger and many others.

The exposure: Enforcement priorities at DOJ and FTC have expanded following the enactment of the ACA, with a record number of merger applications from healthcare organizations challenged in 2011 (17). Review of mergers and market share applies to all, including newer networks, ACO’s and like models.

The response: Increased attention beginning in the last decade has made customized coverage solutions for larger organizations the norm, with increased underwriting interest in process, history, expansion
The highlights:

- In the Healthcare setting, organizational liability for violation of the Federal False Claims Act or any federal, state or local regulation concerning fraud, abuse or waste in the Medicare and Medicaid System.

- To simplify, the federal government, through the actions of various agencies, maintains a substantial list of activities which are considered “fraudulent” or “abusive” as our healthcare buyer is concerned. Universally, neither state of mind nor intent are required for a determination of fraud or abuse.

The exposures: Some examples of the Regulatory Issues that our Healthcare clients may be exposed to:

- Billing for services/equipment not rendered
- Billing more than one time for the same service/equipment
- Billing under the wrong code to generate a higher or more frequent payment (upcoding and unbundling)
- Payment of kickbacks to obtain patient referrals
- Falsification of cost reports or patient records to obtain reimbursement
Regulatory Fraud and Abuse – it’s not just protecting your parents’ Medicare anymore…

**The response:** The resurrection of the Federal False Claims Act and other statutes in the 1990’s applied to waste and abuse of Medicare, Medicaid and private funding within publicly traded healthcare organizations and large systems. However, the continued waste within CMS administered programs, and the known cost of new initiatives (including provisions of the ACA and funding ACO milestones), has prompted increased enforcement to expand beyond the large provider to include the outpatient, the small and the new. Two recent expansions occurred in 2009:

- **Fraud Enforcement and Recovery Act (FERA) of May, 2009** expanded the scope of liability of our insureds under the FCA, and increased the powers of the Attorney General to delegate authority to conduct Civil Investigative Demands prior to intervening in an FCA action.

- **HEAT Task Force** – DOJ and HHS announced the creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT) in May, 2009. This elevated the fight against Medicare fraud from one handled by many federal agencies to a Cabinet level priority. This multi agency team of federal, state and local investigators has focused on Medicare data analytics and community policing to combat fraud.

- **Insurance** – limited, tailored solutions have been available since the late 1990’s with focus on compliance, organizational size and number of interactions with federal programs. Newer organizational types such as ACO’s are considered to be intermediaries who bill for services.
The early actions: Traditional use of the whistleblower provision of the Federal False Claims act to recognize both unintentional (McLeod Regional Health System) and repeat fraud on the part of a publicly traded corporation (Columbia HCA).

Today’s enforcement: Increased use of multiple agencies, (including specialized bureaus within DOJ and FBI) and expanded routine and non routine contract audits (RAC, ZPIC) have resulted in multi-state and mixed provider indictments, many involving smaller medical groups, home health agencies and ancillary providers of physical and occupational therapy).

The new providers: A federal billing intermediary is not exempt from enforcement so the ACO and others become additional enforcement targets.