DPC Legal Potpourri
With a Texas Twist

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DPC Nuts & Bolts to 2.0
Irving, Texas
Topic Categories

• State DPC or Insurance & HMO Law
• Affordable Care Act
• HIPAA
• Federal Tax Laws
• Dispensing, Pathology & Lab Direct Billing
• Medicaid (today) & Medicare (tomorrow)
Sec. 101.002. DEFINITIONS. In this chapter:

(1) "Insurer" includes:

(A) a corporation, association, partnership, or individual engaged as a principal in the business of insurance;

(B) an interinsurance exchange or mutual benefit society; or

(C) an insurance exchange or syndicate.
The “Business of Insurance”
Includes:

• receiving or collecting any consideration for insurance, including:
  • (A) a premium;
  • (B) a commission;
  • (C) a membership fee;
  • (D) an assessment; or
  • (E) dues;

• contracting to provide in this state indemnification or expense reimbursement for a medical expense by direct payment,
Texas HMO Definition
(Title 6-C-843-A)

• "Health maintenance organization" means a person who arranges for or provides to enrollees on a prepaid basis a health care plan, a limited health care service plan, or a single health care service plan.

• "Health maintenance organization delivery network" means a health care delivery system in which a health maintenance organization arranges for health care services directly or indirectly through contracts and subcontracts with physicians and providers.
Health Care Plan

• "Health care plan" means a plan:
• (A) under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of health care services; and
• (B) that consists in part of providing or arranging for health care services on a prepaid basis through insurance or otherwise, as distinguished from indemnifying for the cost of health care services.
Limited Health Care Service Plan

• "Limited health care service plan" means a plan:

• (A) under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of limited health care services; and

• (B) that consists in part of providing or arranging for limited health care services on a prepaid basis through insurance or otherwise, as distinguished from indemnifying for the cost of limited health care services.
Single Health Care Service Plan

- "Single health care service" means a health care service:
- (A) that an enrolled population may reasonably need to be maintained in good health with respect to a particular health care need to prevent, alleviate, cure, or heal human illness or injury of a single specified nature; and
- (B) that is provided by one or more persons licensed or otherwise authorized by the state to provide that service.
- (26) "Single health care service plan" means a
State DPC Law – Texas Example

• HB 1945 passed on May 28, 2015
• Now found in Texas Occupations Code
  Chapter 162 Subchapter F
(1) "Direct fee" means a fee charged by a physician to a patient or a patient's designee for primary medical care services provided by, or to be provided by, the physician to the patient. The term includes a fee in any form, including a:

• (A) monthly retainer;
• (B) membership fee;
• (C) subscription fee;
• (D) fee paid under a medical service agreement; or
Tex Occ Code Subchapter F

(2) "Direct primary care" means a primary medical care service provided by a physician to a patient in return for payment in accordance with a direct fee.

(3) "Medical service agreement" means a signed written agreement under which a physician agrees to provide direct primary care services for a patient in exchange for a direct fee for a period of time that is entered into by the physician and:

(A) the patient:
(4) "Physician" includes a professional association or professional limited liability company owned entirely by an individual licensed under this subtitle. (Think CPOM!)

(5) "Primary medical care service" means a routine or general health care service of the type provided at the time a patient seeks preventive care or first seeks health care services for a specific health concern, is a patient's main source for regular health care services, and includes:
Sec. 162.253. DIRECT PRIMARY CARE NOT INSURANCE. (a) A physician providing direct primary care is not an insurer or health maintenance organization, and the physician is not subject to regulation by the Texas Department of Insurance for the direct primary care.

(b) A medical service agreement is not health or accident insurance or coverage under Title 8, Insurance Code, and is not subject to regulation by the Texas Department of
Tex Occ Code Subchapter F

• Sec. 162.254. BILLING INSURER OR HEALTH MAINTENANCE ORGANIZATION PROHIBITED. A physician may not bill an insurer or health maintenance organization for direct primary care that is paid under a medical service agreement.
Sec. 162.255. INTERFERENCE PROHIBITED. (a) The board or another state agency may not prohibit, interfere with, initiate a legal or administrative proceeding against, or impose a fine or penalty against:

(1) a physician solely because the physician provides direct primary care; or

(2) a person solely because the person pays a direct fee for direct primary care.

(b) A health insurer, health maintenance organization, or health care provider as that
Tex Occ Code Subchapter F

• Sec. 162.256. REQUIRED DISCLOSURE. A physician providing direct primary care shall provide written or electronic notice to the patient that a medical service agreement for direct primary care is not insurance, prior to entering into the agreement.
State DPC Law Comparison

• “Not Insurance” Protections
• Clean DPC Definition (double dipping prohibition)
• Mandatory “Not Insurance” Disclosures
• Written Agreement Requirements
• Policing Authority – Ideally the medical board
• Data reporting obligations (avoid!)
• Separate licensure process (avoid!)
Affordable Care Act

- HHS “shall permit a qualified health plan to provide coverage through a qualified direct primary care medical home plan that meets criteria established by the Secretary.“
- A "Direct Primary Care Medical Home" plan is defined as “an arrangement where a fee is paid by an individual, or on behalf of an individual, directly to a medical home for primary care services, consistent with the program established in Washington.“
- Insurance Requirement – Health Sharing
HIPPA Buzz Words

- Covered Entity – Do you electronically transmits health information in connection with one or more standard transactions?
- Business Associate - To be a business associate, you need to be providing certain enumerated services to or on behalf of a covered entity.
- Protected Health Information
- Treatment, Payment & Operations
HIPAA – DPC Approach

- Risk Mitigation Focus
- 1st Defense – Not a Covered Entity
- 2nd Defense – Complied with Requirements
  - “Risk Assessment” (updated annually)
  - Compliance Evidence (privacy & security rules)
  - Use Forms (NPP, BAA, etc)
  - Accounting of Disclosures (ability to provide)
HIPAA – Patients’ Rights

• a. To receive a Notice of Privacy Practices.
• b. To see or receive a copy of his/her protected health information (PHI).
• c. To request that his/her PHI be corrected.
• d. To ask for PHI to be sent to him/her at a different address or a different way.
• e. To request limits on how his/her PHI is used and disclosed.
• f. To receive a list of disclosures.
HIPAA – Notice of Privacy Practices

• This sets up default terms for sharing PHI
• If an activity is not covered in the Notice, the patient's authorization is required before his/her PHI is used or disclosed for the activity.
• So – if the patient is very concerned about privacy, should he sign or not sign your notice of privacy practices?
Tax Laws

• "Gap Plan" and "Health Plan" under § 223(c)
• "Qualified Medical Expense" under § 213(d)
• Health Reimbursement Arrangement?
• Health Savings Accounts?
• $100 per day "excise tax" under § 4980(d)
In Office Dispensing
Tx Occ Cd Title 3-B-158

• Sec. 158.001. PROVISION OF DRUGS AND OTHER SUPPLIES. (a) A physician licensed under this subtitle may supply a patient with any drug, remedy, or clinical supply necessary to meet the patient's immediate needs.

• (b) This section does not permit a physician to operate a retail pharmacy without complying with Chapter 558.
Pathology Direct Billing
(Texas) Medicaid (1)

• Individual providers who are not currently enrolled in Texas Medicaid and whose only relationship with Texas Medicaid is to order or refer supplies or services for Texas Medicaid-eligible clients must enroll in Texas Medicaid as participating providers. This requirement is in accordance with provisions of the Affordable Care Act of 2010 (ACA), 42 CFR §455.410(b), which requires all ordering or referring physicians or other professionals who order or refer supplies and services under the
These providers can enroll online using the PEP tool by clicking the check box for Ordering/Referring Provider, or they can use the streamlined paper Texas Medicaid Provider Enrollment Application Only, which is available for download on the TMHP website at www.tmhp.com.

The ordering or referring-only enrollment application is for individual providers who are not currently enrolled as a billing or treatment provider.
Questions?

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