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Physicians fighting UnitedHealthcare's decision to drop 2,000 from Medicare Advantage

Skirmish in North Carolina could be harbinger of other state fights

Doctors' groups are gaining ground in their fight against UnitedHealthcare's decision to remove 2,000 providers from its Medicare Advantage networks. A federal judge in Connecticut refused a request to throw out an injunction prohibiting the payer from dropping doctors from the networks, and the battle could signal that doctors don't have to take these decisions lying down.

The lawsuit was filed by the Fairfield County Medical Association and the Hartford County Medical Association in November 2013, and the preliminary injunction was issued in December. The most recent court action is encouraging because it suggests physicians have a legitimate argument that being arbitrarily dropped by UnitedHealthcare could be detrimental to their practices, says **Mark S. Thompson,** executive director of the Fairfield County Medical Association in Shelton, Conn.

He notes that the UnitedHealthcare drops first came to light when a patient contacted a Connecticut physician upon hearing that the physician was no longer part of the Medicare Advantage network. The physician had not heard yet that he was being dropped and said the patient must be mistaken.

"The physician then called UnitedHealthcare, and a representative told him, 'It's true, doctor, you're about to be terminated from the Medicare Advantage network,' " Thompson explains. "The doctor asked why, but they had no answer and just told him he was to be dropped as of February 2014. He was told he would be getting a letter soon notifying him, and the doctor in turn called us to see if the medical association knew anything about it."

Thompson's association contacted UnitedHealthcare for an explanation and was told that the company was poised to drop 2,250 physicians from the network "as part of UnitedHealthcare's Medicare optimization program."

"It took my breath away," Thompson recalls. "United

was the largest provider of Medicare Advantage services here in Connecticut, and I couldn't imagine a company in one fell swoop dropping 2,250 primary care and specialists across the state. This had to be a third of their network here in Connecticut."

When Thompson asked why the company was making such a huge move, the representative told him that UnitedHealthcare "needs to optimize our profitability," he recalls.

"They came right out and said it," Thompson says. "It all has to do with how these Medicare Advantage programs are reimbursed by the federal government. As everyone in the industry is being squeezed, so are the Medicare plans. The actuaries at UnitedHealthcare had figured out which patients were costing them more money and which were costing them less."

UnitedHealthcare could not legally drop the patients, so instead it dropped the physicians treating the older, sicker, more complex patients, according to Thompson.

"That's how the companies are optimizing their profits," Thompson says. "The physicians' largest concern was that they had patients they treated for 20 years and now they couldn't treat those patients anymore. The timing was terrible, because United didn't tell patients until mid-October and they had to make a decision by December 7. Many patients didn't know this change was about to happen to them."

"The actuaries at UnitedHealthcare had figured out which patients were costing them more money and which were costing them less."

—Mark S. Thompson

Forcing those patients into other plans could lead to other payers taking on too many high-cost patients and then taking the same action as UnitedHealthcare, Thompson says. There could be a domino effect in the state and even across the country, he adds, which is one fear that prompted the medical associations to file suit. The lawsuits are intended not only to bring immediate relief to the affected Connecticut physicians but also to contain the UnitedHealthcare strategy before it gains momentum among other payers, Thompson says.

Payer ordered to consider appeals

The lawsuit seeks to stop UnitedHealthcare from arbitrarily dropping the physicians and instead leaving them on the plan as the parties move to arbitration, which is required by the payer's contract. Staying on

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the plan during the dispute is crucial, Thompson says, because physicians will be more successful in arguing to stay on the network than arguing to be put back on it. In refusing the payer's effort to lift the injunction, the judge issued a new 30-day appeal period for all physicians being dropped by United. Physicians would have this time period to allow filing for arbitration regarding their termination.

A key complaint is that UnitedHealthcare is dropping the physicians from the network without providing a reason, which is a violation of the plan contract, says Thompson.

"They told physicians 'we're dropping you because we can.' That was the only reason they gave," he says. "They never expected in a million years that the doctors would go to court and seek the last stage of arbitration, but some of them were concerned about long-time patients, some wanted a good reason for being dropped, and there were some who just wanted to poke the insurer in the chest a little bit and say they weren't going to be pushed around like this. It's David and Goliath, but so far David is faring very well in all of this."

Dermatologist **Robin Oshman, MD, PhD,** in Westport, Conn., says she and others were frustrated by the lack of cause. Even if the UnitedHealthcare contract allows appeals, without a cause for dismissal there is nothing to appeal, she explains.

"You know that it wasn't due to the way you practiced because they allowed you to stay in their other programs," Oshman says. "But when they do that, it sends a message to the patients in the Medicare Advantage network that *was* a quality problem with your care. It mars the reputation of the physician and causes a lot of confusion among patients."

UnitedHealthcare spokesperson **Jessica Pappas** says the company's dismissal of physicians from Medicare Advantage is a response to the changing health care landscape, and she expects to see other payers follow suit.

"This is part of the broader transformation that is underway across the healthcare system," she says. "It is an environment in which providers, physicians, hospitals, and insurers are being challenged to provide better ways to care for a rapidly growing senior population and to do so in a way that is more efficient and effective."

UnitedHealthcare's effort to streamline its networks "is ongoing and will continue through the rest of 2014," Pappas says.

Case shows doctors not powerless

Roy W. Breitenbach, JD, an attorney with the law firm of Garfunkel Wild in Great Neck, N.Y., is the attorney who argued the case in Connecticut on behalf of the medical associations. He notes that Connecticut was just the first state to feel the effects: UnitedHealthcare is now terminating physicians from networks across the country in a similar fashion. The UnitedHealthcare contracts stated that physicians could be terminated from the payer's plans only on the provider's annual renewal date, he explains, but the payer got around that requirement by taking advantage of the contract clause

New York also looking at litigation with UnitedHealthcare

Connecticut could be joined by physicians in New York state who are facing similar dismissal from UnitedHealthcare plans, says **Sam L. Unterricht, MD,** president of the Medical Society of the State of New York (MSSNY). The New York physicians had sought the same injunctive relief, but differing state laws complicated that effort, and MSSNY decided to wait for the outcome in Connecticut. After the recent Connecticut ruling, MSSNY's lawyers approached United's legal counsel in order to see whether they were willing to agree to the period of appeal and arbitration, since a 30-day appeal could avoid any further legal action while providing relief to the affected physicians in New York.

UnitedHealthcare refused the offer, and so MSSNY will take it to a judge in hopes of convincing UnitedHealthcare to agree to this concept without having to further litigate the matter, Unterricht says.

Clarification

The February issue of **MCCRA** incorrectly stated that Harrison College is located in Evanston, Ill. The correct location is Indianapolis.

allowing it to unilaterally amend the contract.

The contracts were amended to remove the physicians from the Medicare Advantage network but leave them in other UnitedHealthcare plans, Breitenbach explains. He argued in court that the dismissals violated the Medicare regulations, which require a reason for being terminated and a reasonable appeal process. He also argued that the terminations violated the terms of the contract because the right to amend the contract cannot be used to dismiss physicians from a plan.

A number of legal sources and attorneys general provided amicus briefs in support of the Connecticut physicians, Breitenbach notes.

"The physicians feel very strongly that this sets a good precedent that United can't just decide willy-nilly to narrow networks like this," he says. "We think it has meaning beyond Connecticut because United has contracts across the country in which they've tried to bulletproof themselves from any arbitration or appeals. But we have shown that there is a way around that and there is a way to challenge UnitedHealthcare and get some traction."

HHS suspends RAC appeals for two years, impact could be great

HHS recently announced that the backlog on Recovery Audit Contractor (RAC) appeals is so big that it will not accept any new appeals until it is cleared, which may be as long as two years. The effect on physician practices could be significant, but there are steps they can take to minimize the damage.

There are more than 460,000 pending appeals, HHS reports. The moratorium will not affect appeals fielded directly by Medicare beneficiaries.

The prospect of two years without RAC appeals immediately prompted criticism from the physicians who could be affected. Daniel Landon, senior vice president of government relations with the Missouri Hospital Association, wrote a letter to the state's congressional delegation calling the moratorium "unconscionable."

"Providers aggrieved by a RAC payment denial—and who are twice as likely to win the appeal as lose it—are placed in administrative purgatory for years," Landon wrote. "There is no conceivable way this can constitute adequate due process."

The potential effect on physicians is huge, says **Robert Magnuson,** principal advisor with Impact Advisors, a healthcare information advisory services firm in Napersville, Ill. The audit firms can reach back three years and examine sets of particular claims that may be incorrectly billed, which can add up to a significant number of targeted bills for a physician practice. Once they discover potentially incorrectly billed claims, the RAC firms will seek a "take-back" from the provider for the incorrect billing. The RAC firms have a built-in collection incentive that allows them a portion of the recovery.

The backlog is essentially caused by two factors, explains Magnuson. First, RACs have examined a huge volume of claims. In turn, they have sought a large number of take-backs. This large volume of claims has made the appeal process a burden for the provider administrative and clinical staff. Second, the providers have often sought the assistance of private firms that specialize in contesting these claims.

"Thus, you have a situation where the RACs are likely seeking take-backs for too many claims, since a majority are won on appeal, and at the same time the providers are likely contesting too many claims. Many providers are contesting every claim," he says. "The Administrative Law Judges are overwhelmed with the volume of appeals. The moratorium by HHS is designed to loosen the load on the Administrative Law Judges."

The moratorium's effect on physician practices will depend on the percentage of Medicare patients, notes Magnuson. Another risk, however, is that other payers may follow HHS' lead. The insurance companies have always done third-party audits, but Magnuson says he is seeing a big upswing in audits now that HHS and the RACs have found so many supposed overbillings.

Physicians covered by hospital billing, such as emergency physicians and specialists, could see more impact

from the moratorium, Magnuson says. Hospitals may be hit harder by the audit delays than physicians, he says.

In the meantime, Magnuson suggests that physician practices assess their dependence on Medicare billing and how much they have been appealing RAC audit results in the past. If a significant amount of money is tied up in contested take-backs—and particularly if a practice has been depending on a regular percentage of those appeals being paid—that practice may need to plan for reduced revenue for the next two years or so. There is no reason to think that the percentage of appeals won by physicians will be different after the moratorium is lifted, but those eventual funds will be significantly delayed.

"The Administrative Law Judges are overwhelmed with the volume of appeals. The moratorium by HHS is designed to loosen the load on the Administrative Law Judges."

—Robert Magnuson

"I'm loath to predict if we will have a solution any sooner than that, but we certainly need one," Magnuson says. "This moratorium is putting additional pressure on providers who already are being hit hard financially."

Medicaid billing so bad that North Carolina doctors sue everyone—state, vendors, consultants

Doctors are suing North Carolina over the state's Medicaid billing system, in addition to targeting a software vendor and consultants, claiming that complications and errors in the billing system resulted in financial losses to physician practices and harm to patients.

Seven medical practices filed suit against the state Department of Health and Human Services (DHHS); Computer Sciences Corporation (CSC), the company that built and operates the Medicaid billing system; SLI Global Solutions, a consulting company that tested the system; and Maximus Consulting Services, which conducted independent reviews. The practices asked the court to be certified as a class that would represent the state's 70,000 Medicaid providers.

Known as NC Tracks, the Medicaid billing system has been widely criticized in news reports, state audits, and legislative hearings. The lawsuit states that, "The proof of CSC's wrongdoing was the disastrous state of the software upon go-live. Medicaid providers experienced hundreds of problems with NC Tracks, and the system could not reliably perform its core function of processing reimbursement claims."

The state auditor released a report in 2013, before the state started using NC Tracks, questioning the validity of the testing regimen. A December audit noted more than 3,200 deficits in the system since July 1; 800 of those deficits had not been fixed by the end of the year. DHHS released a statement saying it could not comment on the lawsuit other than to point out the system had fewer problems than other systems of similar size and complexity. The software and billing companies denied comment other than to say the lawsuit was without merit.

The software system went live on July 1, 2013, and physicians saw an immediate drop in reimbursement, says **Camden R. Webb, JD,** an attorney with the law firm of Williams Mullen in Raleigh, N.C., who is representing many of the physicians suing the state. Some providers were not being paid at all; others saw inconsistent or partial payments on certain codes but none on other codes.

"It all seemed to be traceable back to something being wrong with the software system the state bought," Webb says. "The implementation really got off track. It appeared that most of the parties involved in the implementation knew this thing wasn't going to work, but they still went ahead with the implementation anyway. Doctor's practices are hit worse than anyone else."

About 62% of physician practices in North Carolina report they are receiving accurate reimbursements, compared to 80% of hospitals and 75% of pharmacies, Webb says. Some physician practices have been hit so

hard that up to half of their revenue has disappeared for months, with no indication of when it will resume, he says.

In addition, those practices are incurring expenses from the significant administrative time required to address the problem, employee overtime, and lost clinical time. "We know of a few practices that just closed their doors completely," Webb says. "The real shame of it is that some of the practices just decided not to take Medicaid anymore. One of the biggest OB-GYN practices in the state decided not to take Medicaid anymore because of all this trouble, and that's a real detriment to the people of the state who need that Medicaid care."

Other states could follow same path

The case could have implications for physician practices outside North Carolina, Webb says. The dispute in that state is specific to the Medicaid software system developed there, but Webb suggests that similar problems could arise with another state's system. The outcome of the North Carolina suit could influence how those states address their software issues, he says.

Even if the software was fixed and worked reliably, North Carolina physicians would not be made whole, Webb says. In addition to a 3% decrease in payment for some specialists, one of the bones of contention in North Carolina is how the state abruptly changed the reimbursement for dual-eligibles on July 1, 2013, when the new system went live. Physicians were reimbursed significantly less than under the previous system, and Webb says the financial impact has been enormous.

"Some primary care physicians can decline Medicaid and avoid that hit, but other specialists have to take those patients and they're just being massacred," Webb says. "They take the patient and the state shorts them on reimbursement to save some money on Medicaid. But they made these changes without going through the proper procedures."

The North Carolina lawsuit is more a political statement than a legal maneuver, says **Martin Bienstock, JD,** partner with the law firm of Weisbrod Matteis & Copley in Washington, D.C. Martin is a former assistant attorney general and senior legal advisor to the Governor of New York, and special counsel to the New York Department of Health, where he drafted and negotiated dozens of state laws and implemented statewide regulatory enforcement efforts impacting more than 100 healthcare institutions statewide.

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—Camden R. Webb, JD

The state presumably already wants to pay the Medicaid reimbursements but can't because the software system doesn't work, Bienstock says. A judge's order to pay won't fix the software, but the threat of sanctions, judgments, and bad publicity may add extra incentive to get moving on a solution, he says.

"This isn't that different from the Obamacare rollout, where the initial system was deeply flawed after two years of preparation," Bienstock says. "Then the president said we were going to fix it, and that added the momentum to actually get it done rather than a lot of officials talking about it and passing the responsibility on to one another. That's what the North Carolina physicians are hoping for, a judge who can put some motivation into the people responsible for fixing the software."

Bienstock suggests that the type of legal action pursued in North Carolina is not advisable for the individual physician practice that is frustrated with the state's billing and reimbursement system. "It's only when you have a systemic problem like they have in this state, then the most affected providers can band together and pursue a remedy," he suggests. "You don't take that approach when the problem is practice-specific, but the scope of these software systems is such that you can have a statewide problem that requires a lawsuit that sends a shot across their bow and gets a court involved to help solve the problem."

No more delays for ICD-10, but yes to end-to-end testing

The move to ICD-10 will not be delayed again, according to CMS Administrator Marilyn Tavenner. However, CMS has listened to one of the strongest requests from the healthcare community and agreed to conduct end-to-end testing before the system goes live.

The nationwide conversion to the ICD-10 family of diagnostic and procedural codes will be implemented as planned on October 1, 2014, Tavenner said recently in her keynote address at the Healthcare Information and Management Systems Society convention in Orlando, Fla.

"There are no more delays, and the system will go live on October 1," she said. "Let's face it guys, we've delayed this several times and it's time to move on."

There also will be no rollback of compliance dates for stage 2 meaningful use compliance, Tavenner said. Providers had been petitioning for a delay in the compliance dates and more flexibility instead of the "all or nothing" approach to determining compliance. July 1, 2014, is the last compliance date for beginning a 90-day proof of meaningful use.

CMS did give in to the many demands for end-to-end testing of ICD-10 codes before implementation. After much resistance, CMS recently reversed its policy and announced it will initiate end-to-end testing of Medicare claims using the new ICD-10 diagnostic codes. End-to-end means the new codes will be tested all the way through the reimbursement system, from provider to payer and through all the intermediaries.

The decision was praised by **Susan Turney, MD, MS, FACP, FACMPE,** president and CEO of MGMA, which had pushed for the testing.

"MGMA urges CMS, however, to expand the scope of this testing approach to include any provider who wishes to test with them, as well as quickly disseminating results from all Medicare and Medicaid testing efforts," Turney says. "This more robust testing is imperative to identify potential operational problems similar to what was experienced with the rollout of healthcare.gov. At the same time, it will help to decrease the potential of catastrophic cash flow disruption that could impact the ability of practices to treat patients."

AMA study predicts higher ICD-10 costs than expected

The mandated implementation of the ICD-10 code set will be dramatically more expensive for most physician practices than previously estimated, according to an updated cost study initiated by the AMA and conducted by Nachimson Advisors.

The 2014 study found that in some cases, the estimated ICD-10 implementation costs are nearly three times higher than the previous predictions contained in a landmark 2008 study, also produced by Nachimson Advisors.

The federal government requires the healthcare industry to transition to the ICD-10 code set for reporting diagnoses on all healthcare claims and other transactions as of October 1, 2014. Implementing ICD-10 will result in a fivefold increase in diagnosis codes from the current 13,000 codes to a staggering 68,000 codes—a massive administrative and financial undertaking for physicians who are already overwhelmed by overlapping regulatory requirements and uncertainty in a rapidly changing healthcare landscape.

In light of the study findings, the AMA recently sent a letter to HHS Secretary Kathleen Sebelius asking her to again reconsider the ICD-10 mandate.

"The markedly higher implementation costs for ICD-10 place a crushing burden on physicians, straining vital resources needed to invest in new health care

delivery models and well-developed technology that promotes care coordination with real value to patients," said AMA President Ardis Dee Hoven, MD, in the letter. "Continuing to compel physicians to adopt this new coding structure threatens to disrupt innovations by diverting resources away from areas that are expected to help lower costs and improve the quality of care."

In 2008 the predicted cost to implement ICD-10 ranged from $83,290 for a small practice, $285,195 for a medium practice, and $2,728,780 for a large practice. Based on new information, the 2014 study found the following cost ranges for each practice size based on variable factors such as specialty, vendor, and software:

- Small practice: $56,639–$226,105
- Medium practice: $213,364–$824,735
- Large practice: $2,017,151–$8,018,364

Two-thirds of physician practices are projected to fall into the upper range of current cost estimates, which are considerably higher than the 2008 estimates. These practices are expected to incur major costs associated with software upgrades to accommodate the transition to ICD-10. In addition to software upgrades, the total costs include the expense of training, practice assessments, testing, payment disruptions, and productivity loss for physicians.

The 2014 estimates include much higher figures due in part to significant post-implementation costs, including the need for testing and the potential risk of payment disruption. CMS has estimated that claim denial rates could increase 100%–200% in the early stages of coding with ICD-10.

Costs are not the only challenge facing physicians in ICD-10 implementation. Data shows that software vendor readiness for the new code set is significantly lagging. Few practices, therefore, have been able to conduct appropriate testing or implement workflow changes to ensure the codes are working as intended.

Current cost estimates

	Typical small practice	Typical medium practice	Typical large practice
Training	$2,700–$3,000	$4,800–$7,900	$75,100
Assessment	$4,300–$7,000	$6,535–$9,600	$19,320
Vendor/software upgrades	$0–$60,000	$0–$200,000	$0–$2,000,000
Process remediation	$3,312–$6,701	$6,211–$12,990	$14,874–$31,821
Testing	$15,248–$28,805	$47,906–$93,098	$428,740–$880,660
Productivity loss	$8,500–$20,250	$72,649–$166,649	$726,487–$1,666,487
Payment disruption	$22,579–$100,349	$75,263–$334,498	$752,630–$3,344,976
Total costs	**$56,639–$226,105**	**$213,364–$824,735**	**$2,017,151–$8,018,364**

Source: AMA