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LAW ALERT

HEALTH

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Medicare Advantage Terminations: Thinning The Herd Of Qualified Participating Providers

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"Thinning the herd" is the process of removing from the population, by any means necessary, those who cannot or should not survive. Emblem, United Healthcare and other major health insurers, have undertaken a corporate sponsored "thinning of the herd" of participating physicians and have done so by dispatching thousands of notices informing them that their time has come: despite providing admittedly high-quality care to their insured patients, their provider agreements are unilaterally terminated or simply not renewed.

Despite record profits, health insurers point the finger of blame at the government, noting that the Affordable Care Act will be paid for, in part, by cutting by $200 billion in government payments to their Medicare Advantage plans. The government, on the other hand, contends that the insurance companies are overpaid and that it is doing nothing more than bringing the cost of Medicare Advantage in line with costs incurred under traditional Medicare.

For health insurers, high "quality" is often little more than a euphemism for physicians who do not have high utilization rates and, consequently, cost the insurers less money to deliver care. Those physicians who advocate for their patients, adhere to more comprehensive testing or expensive treatment regimens, find themselves in the "crosshairs". The insurers will thin those providers from the ranks of their Medicare Advantage networks, continue to maintain profits and even qualify for government bonuses by reducing cost.

To facilitate these terminations, insurers have turned to a long overlooked clause in provider agreements that permit them to unilaterally amend the agreement and strip these physicians from

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participating in their Medicare Advantage programs.

While, geriatric patients scramble to identify new primary and specialty care physicians, physicians need to determine whether the actions can or should be challenged.

The controlling federal regulation provides some help and holds that when a Medicare Advantage health insurer terminates a provider's agreement, it must provide sixty days written notice of: (i) its intent to terminate (ii) the reasons for the action, (iii) the standards and profiling data used to evaluate the physician, (iv) the numbers and mix of physicians needed by the plan and (v) the effected physician's right to appeal the action and the process and timing for requesting a hearing and the composition of the hearing panel. [1]

Likewise, New York Public Health Law 4406-d prohibits insurance companies from terminating physicians who advocate for their patients' well being. With a few common sense exceptions, the statute also prohibits insurance companies from terminating a participating provider's agreement without written notice of the proposed action, a real explanation of the grounds for termination as well as notification of the right to a hearing or review.[2]

When participation in Medicare Advantage has been terminated, physicians are well advised to undertake a cost-benefit analysis to determine whether the plan at issue corresponds to a significant percentage of revenue. If so, an objection to termination and a request for a hearing should be lodged. As provided by both state law and federal regulation, physicians should also consider pursuing the disclosure of utilization statistics that may reveal bad faith or evidence retaliatory tactics that bring the propriety of the insurer's action into question.

In other cases, insurers have taken the clever path of least resistance and simply chosen not to renew the provider's agreement to participate in the network. Some insurers use this to "end-run" laws that otherwise requires insurers to articulate cause for termination. Accordingly, one may argue that non-renewal under such circumstances is tantamount to constructive termination and, thus, gives rise to a right to appeal. Indeed, some recent cases may provide a path to relief for physicians whose provider agreements are not renewed.

In *Kamhi v Emblem Health Inc.*, the plaintiff-physician received notice from Emblem that his participation in its various plans would not be renewed.[3] Dr. Cahmi sued, alleging that Emblem's action was based upon prior disputes and, thus, was retaliatory. The court held that if non-renewal is retaliatory, it may be tantamount to bad faith and, therefore, the statutory rights of due process that normally attach only to termination could encompass bad faith non-renewal as well. Emblem's motion to dismiss the lawsuit was denied and Dr. Kamhi was permitted to pursue his claims.

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Similarly, in *Lewis v Individual Practice Associate of Western New York*, Inc., the physician-plaintiff challenged the non-renewal of his agreement, claiming that it too was retaliatory.[4] The court allowed the challenge to the non-renewal under the termination statute.[5] It further held that while the statute seemingly applied only to terminations (and not non-renewals), it was enacted for the purpose of remedying a particular mischief, (i.e., severing physicians for advocating on behalf of patients). In so doing, it determined that, at the very least, the statute's requirement for disclosure of utilization statistics applied to the non-renewal of Dr. Lewis's agreement and ordered disclosure so that Dr. Lewis and the court could determine whether the action was indeed a retaliatory "end- run" of the protections provided by law.

Efforts to "thin the herd" of qualified physicians, whether by way of termination or non-renewal, should not be taken as a *fete accompli*. Proactive measures can be undertaken to determine whether a challenge is in order by taking the following steps:

- Determine whether the Medicare Advantage program that is non-renewed or terminated corresponds to a significant enough portion of the practice's revenues to justify a challenge.
- Experienced counsel should be engaged to determine whether the action is appealable and assure that all deadlines are met.
- Utilization statistics should be demanded and, if the insurer fails to provide or conceals the information, a complaint should be made to Department of Financial Services.
- Bearing in mind that none of these actions are based upon quality of care issues, determine if the action is related to the manner in which the practice advocates for or treats patients.
- The insurer may be put on notice that it will be required to identify and preserve all data pertaining to the practice, the benchmarks used to justify the action and the termination or nonrenewal itself.
- Even when appeal rights do not attach, with the assistance of counsel, decide whether a common sense plea for reconsideration should be made. The plea should address: (a) whether the practice is located in an underserved area, (b) the unique nature of the service provided, (c) whether your utilization statistics have been compared to those with dissimilar practices or patient populations, (d) the number of geriatric patients effected and (e) whether the action may be seen as retaliatory.

The corporate thinning of the herd sponsored by managed care is not the necessarily the death-knell to practices targeted for "termination. Physicians need not feel like "the hunted" and are well advised to consider challenging the action individually or banding together with other similarly situated providers to defray costs and, by sheer strength of numbers, create bargaining power to be used in negotiation or litigation.

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[1] __ 42 C.F.R. § 432.202(d)

[2] __ The statute further holds that have insurers must provide utilization statistics, upon demand, so that the physician may determine whether the action taken us somehow retaliatory

[3] __ 37 Misc. 2d 171 (2012),

[4] __ 180 Misc. 2d 812 (2001),

[5] __ Public Health Law 4406-d