Managed Care Under The Gun;
Suing Your Managed Care Plans

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Since the early nineteen-seventies America has struggled with the cost of providing quality health care to its citizens. In an attempt to control these costs, Congress blessed our healthcare system with formal managed care legislation in 1973. One year later, Congress passed legislation that preempts a large majority of state law claims against managed care organizations. This legislation, the Employee Retirement and Income Security Act (ERISA), has effectively been an iron safe for managed care.

This complicated system of contractual medicine involved several new aspects, including pre-authorization for care, medical necessity determinations, gatekeeper physicians, capitation and many other hoops for both providers and subscribers to jump through. The result was that, for the next thirty years, patients – or, rather, subscribers – provided both their congressional leaders and the courts with a litany of managed care's failures.

Subscribers sued their managed care organizations (MCOs) for denying medically necessary care, for providing sub-standard care and for breaching fiduciary duties. State legislatures attempted to reform the healthcare system at local levels through disclosure laws, mandated benefits and 'patient bills of rights'. But these lawsuits and reforms couldn't crack the iron safe, and the backlash against managed care grew in strength. Only now, at the turn of the millennium, has the iron safe splintered.

Recent participants in the healthcare marketplace have witnessed the cracking of managed care's iron safe through two recent Supreme Court decisions, a stream of successful subscriber-based lawsuits, actions of the state Attorneys General and proposed legislation at both the state and federal level. As far as healthcare providers are concerned, these cracks lead to one significant conclusion - MCOs are liable to providers now more than ever for fraudulent behavior and unfair trade practices.

In the last two years, The Supreme Court has made two decisions that have vitally important ramifications for provider-based causes of action against MCOs. In Pegram v. Herdrich[1], the Court resoundingly declared that the judiciary will not and should not entertain attacks on managed care *as a healthcare system*. Congress and Congress alone is to make normative judgments on managed care. This view was recently and fully supported by the Third Circuit Court of Appeals,[2] the first federal appellate court to cite Pegram. What this means is that complainant-providers must be excruciatingly careful *not* to make sweeping, broadside attacks that label MCOs as fraudulent entities in themselves.

What providers *can* do, however, is claim that the operational and design features of a particular MCO afford it an opportunity to commit fraud, and the MCO took that opportunity. By design, MCOs strive to minimize the provision of both unnecessary healthcare and excessive reimbursement. To do so, they initiate cost containment activities such as utilization review, capitation and physician credentialing. Providers

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[1] 120 S.Ct. 2143 (June 12, 2000).
[2] Maio v. Aetna, Inc., 221 F.3d 472 (3rd Circ. 2000).

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consistently complain, however, that these activities are excessively profit-driven – that MCOs routinely, knowingly and willfully avoid not only the provision of *un*necessary healthcare and excessive reimbursement, but also the provision of *necessary* healthcare and hard-earned reimbursement. Just as the laws MCOs for the following: 1) their routine downcoding, bundling and unbundling of reimbursement claims, 2) their unilateral, take-it-or-leave-it 'offers' of "all-products" clauses, 3) their stout refusals to disclose ever-changing fee schedules and underlying reimbursement methodologies and 4) their 'no-cause' deselection of providers that 'overutilize'. These activities are more than just provider concerns – they are individual cracks in the safe that, when addressed properly, MCOs will be liable for.

Downcoding, Bundling & Unbundling

Downcoding is the reverse of upcoding. It is alleged, and in some cases admitted, that MCOs program their computers to recognize certain combinations and sequences of CPT code submissions and then adjust those submissions to reflect a 'properly coded treatment'; i.e., they change the codes submitted to codes with lower reimbursement rates. Bundling works in a similar manner; MCOs' computers recognize individual CPT code submissions and then 'bundle' them together into a larger CPT code that isn't worth the sum of its parts. Unbundling is to bundling as downcoding is to upcoding. The charge is that MCOs break apart a comprehensive reimbursement claim into individual CPT codes when doing so lowers total reimbursement.

While random MCO downcoding, bundling and unbundling effectively wards off incorrect physician coding, routine or systematic use of these tools is just as fraudulent as routine or systematic upcoding. But whereas the United States Department of Justice protects society from upcoding providers, it is up to providers to protect themselves from downcoding by MCOs.[3] The kicker – and don't think MCOs don't realize this – is that it is costly and time-consuming for providers to first catch and then deal with downcoding MCOs.

But it has been done. In May 1999, physicians provided the Maryland Insurance Administration with documentation of NYLCare Health Plans' systematic downcoding.[4] After an investigation, the Insurance Administration penalized NYLCare $100,000, ordered it to cease and desist downcoding, and began a quarterly review of the MCO's implementation of a coding compliance plan. Other states' departments of insurance have implemented similar, industry-wide regulations. For example, Indiana prohibits MCOs from ever changing *any* code on a provider claim without notifying both the provider and the beneficiary of the change and fully explaining to the provider the underlying rationale.

More importantly, the Supreme Court made it entirely clear that it will not permit MCOs to commit fraudulent activities. In Humana, Inc. v. Forsyth[5], the Court specifically held that health insurers *are* liable for violations of the Racketeer Influenced and Corrupt Organizations Act, otherwise known as RICO.[6] While RICO was originally intended to prevent the spread of organized crime, it is no longer the exclusive tool of United States Attorneys. Private citizens, (e.g., healthcare providers), may now bring

[3] The Department of Justice polices the Medicare and Medicaid programs.
[4] NYLCare is a subsidiary of Aetna U.S. HealthCare.
[5] 525 U.S. 299 (1999).
[6] 18 U.S.C. §§1961 – 1968.

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civil suits claiming that an MCO violated RICO. Successful RICO claimants will not only be awarded compensatory damages and attorneys' fees, but treble damages, as well.

One of the four RICO prohibitions penalizes any person who conducts an 'enterprise' through a 'pattern' of 'racketeering activities'.[7] To prove a 'racketeering activity', a provider must first prove that an MCO takes part in any 'predicate act', i.e., any federal or state crime listed in 18 U.S.C. §1961(c). This list of crimes is *very* broad. While it encompasses some of the crimes typically espoused to organized crime – kidnapping, murder, extortion – it also includes more mundane crimes such as mail and wire fraud. Because of its simplicity, mail fraud is one of the most commonly alleged RICO 'predicate acts'.

To prove mail fraud, the provider must show that the MCO knowingly participated in a 'scheme to defraud'. A 'scheme to defraud' has also been interpreted broadly – one can even be 'defrauded' of "an intangible right to honest services".[8] If providers are able to document an MCO's *routine and systematic* downcoding of their claims for services rendered, they may be able to show that the MCO knowingly schemed to defraud them of their rightfully earned reimbursement.[9] When the downcoded claims are stamped and dropped in the U.S. mail, the MCO commits mail fraud – a racketeering activity. Once this practice is shown to be the MCO's regular way of doing business, you have a pattern of racketeering activities and, voila, a RICO violation.

"All-Products" Clauses

While an MCO's non-negotiable 'offer' of a 'cram-down' or 'all-products' clause does not violate RICO, it does violate other federal and state laws. Providers must be particularly aware of an MCO's inclusion of an 'all-products' clause in provider agreements. Such a clause will usually read as follows:

> 'Company reserves the right to introduce new Plans during the course of this Agreement. Provider agrees to provide covered services to Members of such Plans under applicable compensation arrangements determined by company.'

MCOs assert that these clauses ensure patients' continued access to the physicians of their choice if and when their employers ever switch MCO products. While 'all-products' clauses may marginally benefit subscribers, they can have a devastating effect on a provider's practice.

For example, assume that Dr. Jones agrees to participate as a preferred provider in an MCO's networked PPO. Three months later, the MCO offers a new HMO product to a large number of new enrollees. Because of the all-products clause, the MCO offers Dr. Jones to its new HMO enrollees as part of its 'comprehensive network'. Suddenly – and often without notice – Dr. Jones is required to care for a larger and broader patient base, to operate under various, incongruent policy terms and reimbursement methodologies, and to assume insurance risk.

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[7] RICO defines an 'enterprise' as "any individual, partnership, corporation, association, or other legal entity, and any union or group of individuals associated in fact although not a legal entity." 18 U.S.C. §1961(4). The "regular way of doing business" constitutes a 'pattern'.

[8] 18 U.S.C. §1346.

[9] This is the crux of the theory that has been espoused by a class of providers in a current civil RICO suit against the entire managed care industry, *In re Managed Care Litigation* (S.D. Fla., MDL No. 1334). The theory is supported by Connecticut Attorney General Richard Blumenthal and, most recently, Florida Attorney General Robert Butterworth.

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The all-product clause has a doubly negative effect on small provider practices. First, a smaller practice is more likely to have legitimate reservations about assuming both risk contracts and unknown patient bases. Second, a smaller practice has virtually no negotiating power with a large MCO. Therefore, Dr. Jones' choice becomes 'patients in all products... or no patients at all.'

By offering this choice, however, an MCO may run afoul of the federal antitrust statute – the Sherman Act.[10] The Sherman Act prohibits organizations from 'tying' unrelated products together, e.g., an internet browser and an operating system. If an MCO's HMO 'product' is found to be unrelated to its PPO 'product', the MCO may not tie the two products, i.e., the MCO may not compel a provider that participates in one of its products to participate in the other.

While an influential opinion by the Seventh Circuit Court of Appeals has determined that HMOs and PPOs *are* related products for Sherman Act purposes[11] - and therefore *may* be tied – the Antitrust Division of the Department of Justice (DOJ) does not agree. While examining Aetna's merger with Prudential, the DOJ argued that HMO and PPO plans substantially differ in regard to structure, price, licensing requirements and benefit configurations, and therefore constitute different product markets. After all, MCOs make these same points when they market the products. If either providers or the DOJ test this theory and turn out to be correct, 'all-products' clauses could be eradicated.

But providers should also be aware that non-negotiable 'all-products' clauses may violate their state's unfair trade practice laws and regulations. Kentucky, Maryland, North Dakota and Virginia, to name just a few, have all passed laws that specifically outlaw all-products clauses. Nevada's insurance commissioner ruled that such provisions amount to coercion; Connecticut Attorney General Richard Blumenthal vehemently agrees. Texas Attorney General John Cornyn's settlement with Aetna / U.S. Healthcare precludes the MCO from including 'all-products' clauses in its provider agreements with Texas-based small-group practices. While the best remedy for an all-products clause is to *refuse to agree to it*, providers should be aware that there are both federal and state laws that may grant relief from such clauses – even *after* the contract has been signed.

Refusal to Disclose Fee Schedules and Reimbursement Methodologies

What truly frustrates providers is signing the contract and then being unable to obtain their MCO's latest fee schedules and reimbursement methodologies. While provider agreements often grant MCOs the unilateral ability to *modify* fee schedules and reimbursement methodologies – a questionable provision in itself – provider agreements do not allow MCOs to thereafter *conceal* them. When providers are unable to examine the rates at which they are to be reimbursed, they can neither make sound business judgments nor effectively detect and prevent MCO fraud. This problem is only compounded by an 'all-products' clause; providers are forced to commit to *every* product that an MCO develops, at *any* price that the MCO deems appropriate, and are *never* told what that price is.

Providers should not be passive when an MCO refuses to disclose current fee schedules and reimbursement methodologies. Such a failure to disclose may very well constitute a breach of good faith and fair dealing. The Georgia Court of Appeals recently agreed, declaring that healthcare providers need this information to "calculate for

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[10] 15 U.S.C. §1.

[11] See Blue Cross & Blue Shield v. Marshfield Clinic, 65 F.3d 1406 (7th Circ.1995) (Posner).

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themselves whether they have been fully paid for a particular service under the plan… [and to] ensure that Blue Cross is fulfilling its obligation under the contract."[12] A breach of good faith, a form of breach of contract, may result in restitution damages. Many state and local medical societies are currently lobbying for mandated disclosure laws.

'No-cause' Deselection

Many medical societies are also actively lobbying against MCOs' improper use of the 'no-cause' deselection clause. Many current provider agreements allow MCOs to terminate the MCO-provider relationship for 'no cause'. And even if there isn't a no-cause clause, nothing requires the MCO to continue a provider's participation beyond the term of the agreement. Thus, MCOs are able to 'deselect' or not renew a physician and *not* have to provide a rationale for doing so.

While 'no-cause' clauses are common across many non-healthcare industries, they have come under strict scrutiny in the managed care arena. Providers widely fear that MCOs will terminate their provider agreements for 'no cause' if they make diagnoses, propose treatments and advocate on their patients' behalf in a manner that is not compatible with MCO policy. Without having to provide a rationale for the termination, MCOs are *encouraged* to terminate providers that overutilize or complain about management policies. Providers have gone so far as to claim that the overarching fear of 'no-cause' deselection may lead to the provision of sub-standard care.

ERISA's preemption clause, managed care's iron safe, has traditionally deflected deselected providers' allegations of MCOs' breach of contract. However, courts now appear to be more willing to hear such claims. The watershed case occurred in California, where legislation prohibited an MCO from terminating a physician on the basis of patient advocacy.[13] In 1996, a New Hampshire court extended this holding by declaring that an MCO's termination of a provider 'without cause' violated the state's uncodified public policy and principles of good faith and fair dealing.

The decision had many initial detractors, but a federal court in New Jersey recently agreed, drawing a parallel between a hospital's revocation of staff privileges – where public policy requires a fair, pre-termination hearing – and an MCO's deselection of participating providers. The case's ultimate settlement agreement requires the MCO to treat all 'administratively-based' deselections as 'for cause' terminations; i.e., pre-termination hearings *will be* required.[14]

A provider may be able to obtain damages subsequent to a no-cause termination, as well. An MCO that improperly deselects a provider may be liable for tortious interference with the patient-provider contract. The law deems the patient-provider relationship as contractual in nature. To prove that an MCO tortiously interfered with that contract, a provider must show that the MCO knew of the contract, intentionally interfered with it, and caused the patient to breach it.

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[12] Medical Assn. of Georgia v. Blue Cross & Blue Shield of Georgia, Inc., 2000 WL 776992 at *2 (Ga. Ct. App. June 19, 2000).

[13] See Wickline v. California, 192 Cal. App. 3d 1630 (Cal. Ct. App. 1986). The California courts have recently interpreted this legislation to apply to no-cause terminations by not only MCOs, but also medical centers. See Khajavi v. Feather River Anesthesia Medical Group, Cal. Ct. App., No. C029159 (Oct.10, 2000).

[14] See New Jersey Psychological Assn. v. MCC Behavioral Care, Inc., D.N.J., 96-3080, settlement Oct. 24, 2000.

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By constructing a physician network for its enrollees, an MCO certainly 'knows' about the patient-provider contract. By deselecting a provider, the MCO intentionally interferes with that contract. And although patients are generally free to drop their physicians, deselection often forces a patient to *unwillingly* leave his or her physician for another. In other words, deselection causes patients to involuntarily breach their relationships with their physicians. The last element of the tort, damages, can be shown by a documented drop in reimbursement.

Conclusion

A provider that participates in MCO products must be very sensitive to systematic downcoding, 'cram-down' provisions such as 'all-products' clauses, non-disclosure of fee schedules and reimbursement methodologies, and improper, 'no-cause' deselections. First, providers *must* familiarize themselves with the terms and meanings of their provider agreements. Second, providers should institute their own compliance plans in regard to coding and billing; it is *very* difficult to assert MCO fraud if your own hands are not clean. Finally, providers should contact their local medical societies, state insurance regulators or counsel to remain up to date on improper MCO practices. A provider that suffers from any fraudulent managed care practice is no longer without recourse to the law. As the cracks in the iron safe of managed care begin to widen, providers should not stand by idle.

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