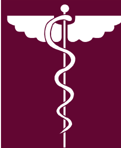
Volume 6, No. 2 Spring 2008

MEDICAL/LEGAL NEWSLETTER



Published by the Onondaga County Medical Society and Wood & Smith, P.C.

A publication for members of the Onondaga County Medical Society

CAN YOU SURVIVE WITHOUT THAT HMO CONTRACT?

Becoming a managed care maverick.

Tired of dealing with insurance companies everyday? Fed up with decreasing reimbursements, increased administrative hassles, and lack of control over your destiny? Ready to say goodbye to managed (mangled) care? Many physicians are thinking that way and some are taking the plunge – withdrawing as a participating provider with private health plans.

What does it mean for a physician to "de-par" from an HMO? What are the pitfalls with non-par status and should you consider going that route? This article will examine those issues.

In order to get licensed by the State, HMOs and other insurers are required to assemble a network of physicians and allied health professionals so that they can assure their customers that licensed professionals are available to handle their healthcare needs as they arise. Having providers under contract gives stability certainty to the network, and it allows the insurer to have a predictable (and usually lower) annual cost for reimbursing those providers. Finally, through the contractual relationship, the insurer is able to bind its network providers to the multitude of policies, procedures and guidelines that are formulated from time to time by the insurer.

> **"physicians who have narrow subspecialty practices or have unusual training and expertise may experience very little change in their volume of patients once they become non-participating."**

From a legal standpoint, cutting the tie with an insurer is rather straightforward. All provider contracts have a section on termination. In most cases, a physician can elect to terminate the provider contract on written notice to the insurer "without cause" on 60, 90, or 120 days prior written notice. Some contracts permit termination at any time during the contract year, while others only allow a window of opportunity – for example, allowing termination on 60 days notice to be effective as of the last day of the year.

At least one local insurer (Excellus) currently has a policy that a physician who withdraws from the network cannot re-apply for membership for three years -- a penalty evidently intended to discourage defections (the policy is not expressly stated in the Provider Manual; instead, it says that *"The Health Plan will consider readmittance based on established policy. Copies of this policy are available upon request from the Credentialing Department.")*

Upon termination of the provider contract, the rules of the Department of Health require the physician to continue to provide medical services to the subscriber during a transitional period (60-90 days) until the completion of current treatment, medically appropriate discharge, or transfer to another physician. In addition, health plans may require the physician to send a written notification to affected patients that the physician has disaffiliated. For example, Excellus requires primary care physicians to notify patients within 15 days after disaffiliation, while specialists have to notify affected patients *before* disaffiliating.

Whether the physician loses any patients as a result of withdrawing from the insurer's network depends on several factors. The three most common types of health plans – HMO, PPO, and indemnity – all have different rules for out-of-network services. Generally, PPO and indemnity products will allow patients to use out-of-network physicians. Some HMO and EPO (Exclusive Provider Organization) products trade a lower premium cost for a requirement to use only network physicians, while POS (Point of Service) and other HMO products will allow the patient be treated by non-participating physicians, albeit at a higher out-of-pocket cost.

INSIDE THIS ISSUE:

Can You Survive Without That HMO Contract?	1
Group Practice Mergers: What's Love Got to Do With It?	3

The Managed Care Bill of Rights in New York guarantees that HMO members have the right to see a physician outside the plan if the plan does not have a physician who can meet the patient's health needs. Therefore, physicians who have narrow subspecialty practices or have unusual training and expertise may experience very little change in their volume of patients once they become non-participating. For example, a patient shouldn't have any problem getting approval for treatment from the sole rheumatologist in the community who does not participate with the health plan. Not the case with the primary care physician.

If an HMO denies a request for a referral to an out-of-network provider, it must send the patient a notice that includes information about how to file a grievance with the HMO. In many cases, the Attorney General's Health Care Bureau has successfully intervened on behalf of a patient whose request to go outside the network has been denied.

A critical factor in determining whether to withdraw from an insurer's network is the anticipated effect on the physician's revenue stream. The ability to charge and collect higher fees may be more than offset by the loss of patients who cannot afford higher out-of-pocket expenses. Only by a thorough analysis of the referral patterns, patient demographics, and the physician's office cost structure can an intelligent business decision be made about ending participation in the plan's network.

"Since the patient of the non-par physician will incur higher out-of-pocket costs, there is a greater risk that the patient will not be able to afford to pay the portion of the physician's bill for which it is responsible. "

If the patient goes to an out-of-network physician, the health plan will usually require the patient to bear the cost of a deductible (e.g., $500 per person) and then the plan will pay a stated percentage (e.g., 70-80%, but sometimes lower) of either the physician's charges or the usual and customary rate ("UCR") for the particular services. Under a managed care contract, the participating physician must accept the health plan's reimbursement (and patient deductible or co-pay) as full payment; however, the non-participating physician may "balance bill" the patient for the difference between the insurer's allowable reimbursement and the physician's charges.

The system of basing reimbursement on UCR is fraught with uncertainty for providers and potential manipulation by the health plans. It is impossible to know the UCR amount until after-the-fact because physicians do not have ready access to the data that makes up the UCR calculation. Ironically, most of the insurers rely on a national database prepared and maintained by Ingenix, a subsidiary of United Health Group.

In February, Attorney General Andrew Cuomo announced that he is conducting an industry-wide investigation into a scheme by health insurers to defraud consumers by manipulating reimbursement rates. The six-month investigation found that Ingenix operates a defective and manipulated database that the largest insurance companies use to set reimbursement rates for out-of-network providers and that two of UnitedHealth's subsidiaries dramatically under-reimbursed their members for out-of-network medical expenses by using data provided by Ingenix. The Attorney General has alleged that United's ownership of Ingenix creates a clear conflict of interest because their relationship gives Ingenix an incentive to set rates that benefit United and its subsidiaries.

For example, the investigation found a clear example of the scheme: United insurers knew most simple doctor visits cost $200, but claimed to their members the typical rate was $77. The insurers then applied the contractual reimbursement rate of 80%, covering only $62 for a $200 bill, leaving the patient to cover the $138 balance.

The uncertainty and flexibility inherent in the Alice-in-Wonderland system of UCR *("UCR means what I say it means")*, however, creates an opportunity for the astute physician to negotiate an appropriate reimbursement rate with the insurer. Indeed, several of the author's clients frequently engage in rate negotiations with insurers *before* rendering medical services to the plan member, usually resulting in an agreement on the part of the insurer to pay a stated percentage of the physician's charges.

For participating physicians, the patient's benefits under the health plan are "assigned" to the treating physician and therefore the participating physician is paid directly by the plan. But for out-of-network physicians, many plans prohibit an assignment of benefits by the patient and therefore payment for medical services will be made to the patient, who in turn must pay the physician. In order to alleviate some of the administrative hassle in submitting claims for reimbursement, some out-of-network physicians will offer to file the claims on behalf of their patients. And some physicians will also file courtesy claims of their own as evidence of the professional services that were provided to the patient.

Continued on Page 4

GROUP PRACTICE MERGERS: WHAT'S LOVE GOT TO DO WITH IT?

Combining medical practices into larger groups – through merger, consolidation or acquisition – is still in style. There are a number of good reasons to consider a practice combination ranging from spreading overhead costs among a greater number of physicians, to pooling resources to acquire expensive facilities or equipment, to supporting or introducing ancillary revenue opportunities, to improving the combined group's ability to attract and retain new physicians. We have seen combinations in the physician area – as well as those involving other professions – which, in retrospect, should never have occurred. The incompatibility of the parties' practice styles, ethics, culture and willingness to work together led to expensive, time-consuming and contentious break-ups. It was not the financial performance of the combined group that doomed the relationship, but the post-combination interpersonal interactions and the failed expectations.

What if following a combination you find that one or more key physicians are unwilling to be part of the new team? What if one group perceives itself as working harder, or being more productive or being clinically superior to the other group? What if one group is subsidizing the other group through the allocation of overhead or ancillary revenues under the combined compensation plan? So you've reduced some overhead and maybe introduced new revenue streams, but was the combination ultimately worth it?

"Successful mergers generally occur between physicians and groups with similar values and work ethics. "

There is an old adage "a merger is like a marriage." There is an older adage about marriages:

> Anyone can organize a wedding, but not everyone can have a long and happy marriage. A wedding takes planning. A marriage requires hard work. A wedding can be had for the cost of a cake and a punch bowl. A good marriage cannot be purchased in any way.

In both mergers and marriages the alliance disintegrates when the parties' expectations during courtship fall short and the lasting benefits fail to materialize.

Successful mergers generally occur between physicians or groups with similar values and work ethics. Certainly there are physician groups and other professional practices that are marriages of convenience. The parties may not like each other, may not respect each other but, together, they are financially successful. Usually, both the success and enmity develops over time. In a practice combination the impact of differences in culture appearing post-consolidation tends to be more acute.

"It is not uncommon that for the initial period following a combination productivity decreases, parochialism increases and commitment to the combined enterprise wanes."

It is not at all uncommon that for the initial period following a combination productivity decreases, parochialism increases and commitment to the combined enterprise wanes. Flaws may not show up until after the groups are combined. Can the combined group handle this?

Due diligence is an important component of any practice combination and involves, among other things, reviewing the parties' finances and operations. As a part of the due diligence process it is important to engage in subjective – or soft – due diligence.

1. Manage expectations. Unrealistic expectations can create discontent. Make sure there are solid business reasons for the combination. Can the benefits be realized and over what period of time? What if they can't? For example, it may take a year to realize any cost savings from the combination and several years to realize the projected benefits, if at all. Centralizing operations – which may involve reassignment or termination of employees, closing of offices, etc. – will involve pain. The participants need to understand this.

2. Are the participants really compatible? What are their values, work ethic and approach to risk? Does one group value a balanced life while the other is focused on working hard and maximizing compensation? Can the parties communicate and can they accept each other's differences? If not, will it engender resentment post-combination? Differences in work ethic can be addressed in the compensation plan. Differences in values cannot.

3. Stress the system. Avoiding conflict in the early going usually means dealing with something much worse

Continued on Page 4

GROUP PRACTICE MERGERS: WHAT'S LOVE GOT TO DO WITH IT?

Continued from Page 3

later on. What are the parties' expectations and what if they do not pan out? Identify and deal with potential "merger killer" issues on the front end. For example, how will the combined practice deal with physicians who are unable – or unwilling – to be team players and attempt to undermine the combination plan? What if they are high producers?

The results of this subjective due diligence review will be a factor in the decision to proceed in the first instance and in the way in which the combination is structured, including governance, compensation and operations.

Like a marriage, a group practice combination takes time, effort, commitment and money to work. Ultimately, the participants need to understand and evaluate what they are giving up by combining, what they plan to get from combining and what will happen – and how they will deal with – a situation in which what they expected to happen did not.

CAN YOU SURVIVE WITHOUT THAT HMO CONTRACT?

Continued from Page 2

The non-participating physician must diligently manage accounts receivable and have a very proactive plan for collecting bills from patients. Since the patient of the non-par physician will incur higher out-of-pocket costs, there is a greater risk that the patient will not be able to afford to pay the portion of the physician's bill for which it is responsible. And unfortunately it is not uncommon for a patient to obtain reimbursement from the health plan only to divert the money for some other purpose than paying medical bills. A patient may spend the money on necessities or luxuries and later file personal bankruptcy, discharging any further liability to the physician who provided medical care (the physician can object to the bankruptcy discharge on the grounds of an unlawful diversion of insurance proceeds, but that avenue of pursuit is time consuming and expensive). The non-participating physician will also send more unpaid accounts to a collection agency. Bad credit problems can be somewhat ameliorated by careful screening of patients and monitoring the aging of receivables so that they don't get out of hand. Many medical practices now accept credit cards for the payment of bills.

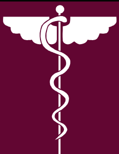
Bailing out of the insurer's network is not for the faint hearted, but with careful advance planning it can reduce the hassle factor and improve the bottom line for *some* medical practices. And just knowing that the option exists – especially if the insurer with whom you are negotiating believes that it is a viable option – can enhance bargaining power in contract negotiations.

VISIT OUR WEBSITE:

www.woodsmithlaw.com

Wood & Smith, P.C. represents physicians, physician organizations and other health care providers on regulatory, business, real estate and tax matters. Our mission is to help our clients plan for and respond to the challenges and opportunities that exist in the health care industry.

WOOD & *SMITH*, P.C.
ATTORNEYS AT LAW
One Lincoln Center, Suite 1110
110 West Fayette Street, Syracuse, New York 13202 (315) 423-0400 Fax (315) 424-1011
Visit our Website at *woodsmithlaw.com*



Medical/Legal Newsletter is a publication of the Onondaga County Medical Society and Wood & Smith, P.C. It is not intended to be used as a substitute for legal advice.