

Managed Care Contracting Is Still A Dangerous Game

By: Michael J. Schoppmann, Esq.

Physicians' animosity toward managed care is, perhaps, at an all time high. At the same time they fear that unless they enroll quickly, quietly and frequently, they will be excluded from the marketplace.

This paradox has led physicians to seek legislative redress while they simultaneously sign managed care agreements with little if any consideration to Michael Schoppmann, Esq. the financial terms or legal obligations created by these contracts - contracts which have been carefully drafted by the managed care companies and their lawyers.

Until recently, physicians have been at the absolute mercy of managed care companies. Sign where indicated, without consideration of the baffling fine print, or be excluded. Now, thanks to the passage of a new law which the Medical Society of the State of New York fought hard to achieve, New York physicians cannot be terminated from managed care contracts without good cause and a due process hearing. This new law can provide enormous protection to physicians throughout the State. However, these protections can be substantially eroded by the very language of the managed care contract a physician may sign.

While a managed care company can no longer terminate a physician at whim, it can terminate a physician for cause-and cause is determined by the language of the managed care contract the physician signs. It is critical, therefore, to consider the fine print before signing a managed care contract. Physicians must know how a managed care company can terminate them. Consider the following: simply failing to advise the managed care company of a change of address or new hours could, under certain contracts, constitute cause for termination. A change in license status or hospital privileges, even if requested by the physician, could also trigger a cause for termination in some contracts.

Under the new law, New York physicians now possess rights virtually unparalleled elsewhere. Basically, the New York Public Health Law, Section 4406-d provides:

A plan may not terminate a contract with a physician without a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing. (Except in case of imminent harm to a patient, determination of fraud, or a final disciplinary action by a state licensing board or other government agency that impairs the physician's ability to practice.)

The notice of the proposed termination must include: a) reason for the proposed action, b) notice that the physician has a right to a hearing or review, before a panel appointed by the Plan, c) a time limit of not less than 30 days in which to request the hearing, and d) the hearing date must be within 30 days of the request for same.

* The hearing panel is made up of (at least) three persons appointed by the Plan. At least one (or one third) must be a clinical peer in the same discipline as the physician under review.

* The panel must render a decision in a timely manner, in writing. A decision to terminate shall be effective not less than 30 days after receipt of the decision by the physician, and not be effective less than 60 days from the receipt of notice of termination. (This is subject to Section 4403, sub. 6, entitling patients to some manner of continued treatment from their treating physician.)

* A Plan shall institute procedures to evaluate performance, which shall be shared with the physician, who may respond and discuss.

* No Plan may terminate or refuse to renew solely because a physician: a) advocated on behalf of an enrollee; b) filed a complaint against the plan; c) provided information pursuant to Sec. 4406; or d) requested a hearing.

Not only must a physician consider termination provisions of the contract, but he or she must also carefully analyze other contract provisions as well, to avoid potential economic disaster. As only several examples:

* Under the terms of some contracts, a managed care company may be able to change its reimbursement rate without a physician's knowledge or consent. Frequently, the contracts require physicians to continue to see the company's patients, even in the event of the company's bankruptcy or inability to reimburse a physician for services rendered to a patient.

* A frightening provision contained in many contracts requires physicians to indemnify the managed care company for its liabilities resulting from a malpractice action and to "hold them harmless" from their decisions concerning whether or not to cover care or treatment. Many medical malpractice policies, however, do not provide for indemnification of the company or cover physicians for the expense of holding the company harmless. A new statute, section 4406-c, sub. 5 provides that no contract may include a provision purporting to transfer to a health care provider, other than a medical group, by indemnification or otherwise, any liability relating to any acts or omissions of the health plan as opposed to those of the health care provider.

* Other potential pitfalls include provisions which could preclude a physician from entering into other managed care agreements and language which gives the managed care company the right to assign a physician's contract to another company, thereby requiring the physician to see patients of another managed care company, even though the physician never agreed to do so. Such assignment could also alter a physician's reimbursement rate.

* Some managed care contracts require what is known as "most favored nation" status. Therein, if the physician signs a contract with another managed care company, at a lower rate of reimbursement, the "most favored" company can demand to receive that lower rate.

These are just some of the issues that must be addressed in analyzing each managed care contract. These contracts are not innocuous. They are binding legal documents which can have serious impact upon a practice and a physician's pocketbook. These contracts have been carefully drafted by lawyers, working for managed care companies. And, they have been drafted to provide maximum protection and flexibility for the managed care companies, with rarely any consideration, whatsoever, for the welfare of the physician.