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PROTECTOR

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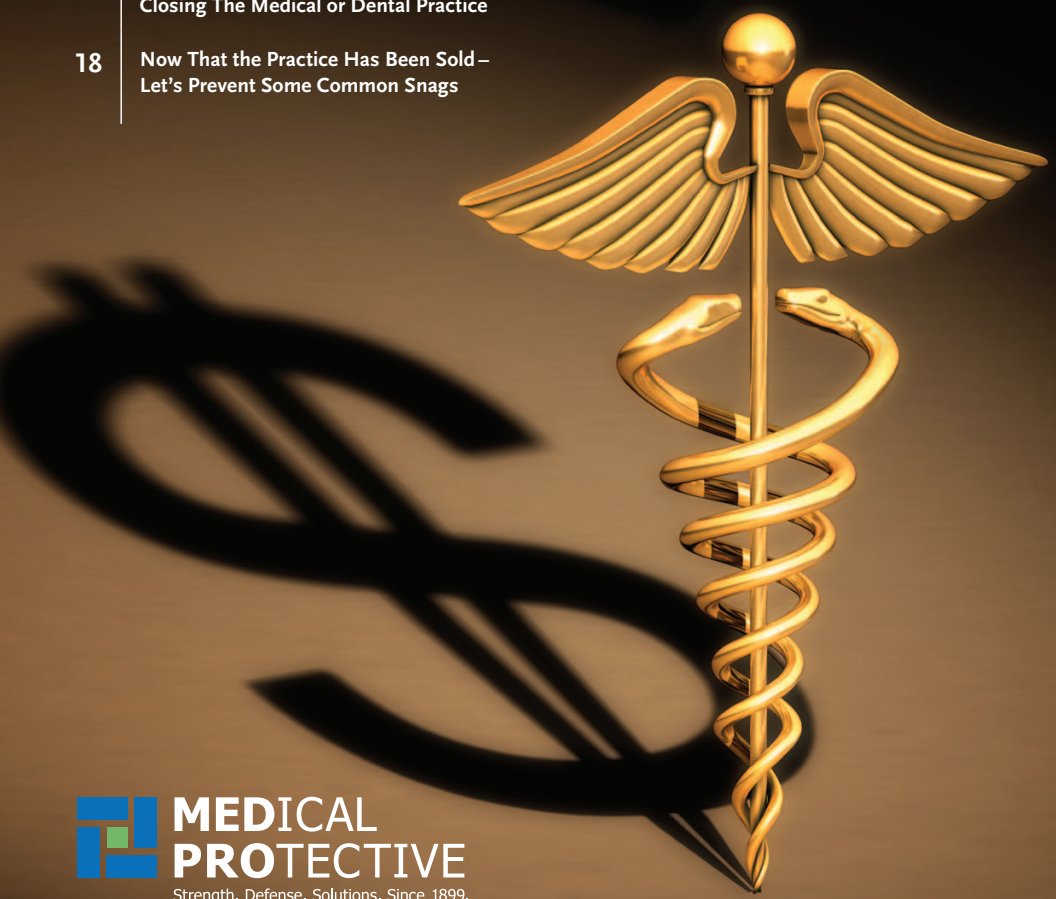

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Medical Protective is pleased to announce a free resource for Continuing Education (CE) hours for our insureds. *Protector* is published three times each year. In order to obtain one hour of free CE, you must read the most recent *Protector* and then complete the applicable on-line test – which can be accessed 24/7 using your Medical Protective policy number to log on at http://www.medpro.com/protector-ce.

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Medical Protective is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. Medical Protective designates this journal-based CME activity for a maximum of 1 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This activity was planned and produced in accordance with the Essentials and Standards of the ACCME.

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Osteopaths, non-physician doctors, and advanced practice healthcare professionals can submit certificates to their professional associations for review. If you pass two tests within one year, you also may be eligible to earn a one-year risk management premium credit which will be applied automatically at your next policy renewal.*

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The Medical Protective website is best viewed in Internet Explorer 7 and higher or Firefox 3.5 and higher. If you have questions, please contact the Clinical Risk Management Education team at: (800) 463-3776.

Dear Medical Protective healthcare provider:

These are confusing times for many healthcare providers. From a patient care perspective, it can be difficult to stay abreast of the latest advances in clinical care. From an administrative perspective, it can be challenging to oversee the business-related aspects of practice management. In addition, these traditional aspects of healthcare are compounded by three additional factors: a) a stagnant economy; b) uncertainty about the long-term effects of healthcare reform legislation ; and c) decreasing reimbursements.

In this issue of *Protector* we continue our examination of administrative challenges that are frustrating healthcare providers. Many of these challenges are associated with federal regulatory attempts to control costs and to design a seamless and interactive health system.

As a result of these systemic pressures, many physicians and dentists are considering selling their practices to larger groups, to health systems, or to practice management organizations. The more information you have, the better able you will be to determine if selling your practice is a wise decision. By reading these articles, you should:

- Have a better understanding of the impetus among large healthcare entities to purchase medical and dental practices;
- Be better prepared to evaluate whether or not to sell your practice;
- Recognize some of the risk issues that need to be resolved to your satisfaction in a sale agreement.

As a reminder, Medical Protective is accredited to provide Continuing Education (CME or CDE) hours for both physicians and dentists. Online access will make it easy for you to complete the test that will accompany each issue. MedPro insureds who successfully complete two tests, in the same year, may also earn premium credits. For more information, see the announcement on the inside cover of this issue of *Protector*. Or, visit our website at www.medpro.com.

Sincerely,

Kathleen M. Roman

Kathleen M. Roman, M.S.
Risk Management Education Leader

Back to the Future:

Another Round of Practice Buy Ups

Kathleen M. Roman, M.S.

Medical and dental practices are being bought out.

If you've been in practice for at least ten years, you'll remember that in the 1990s, hospitals – for competitive reasons – courted and purchased the practices of thousands of physicians, mostly primary care providers. Seeing these medical practices as conduits for patients through their managed care contracts, health systems believed that they could attract larger patient populations by employing more physicians. For a number of reasons, some of which we'll discuss in this article, the plan to achieve this patient growth through ownership of medical practices didn't work.[1]

"The economy, the continuous round of reimbursement cutbacks, and small groups' lack of clout in financial negotiations have become serious challenges for some medical practices."

Recently, hospitals, health systems, and other entities have once again begun to buy up practices, with two differences. First, since the 1990s, many healthcare plans no longer require primary care providers' (PCP) approval for specialty care. This change has lessened hospitals' reliance on the generalist physician for referrals. Recognizing specialists' influence on today's admissions, hospitals today are concentrating their efforts on buying up medical specialty practices. Second, as the buy-up trend expands, business models that didn't exist ten years ago are now being used by corporations that want to invest in the purchase of dental practices.

Physician practice sales are on the upswing.

Despite changes in targeted prospects, many of the current purchase conversations are similar to those that occurred a decade ago. And physicians are listening. According to a survey published by the Medical Group Management Association (MGMA), 25.6 percent of U.S. medical practices were hospital-owned in 2005. By the end of 2008, the number had doubled to 49.5 percent.[2] Experts pose numerous reasons why some physicians decide to sell their practices.

First, many physicians are earning substantially less money than they earned ten years ago. The economy, the continuous round of reimbursement cutbacks, and small groups' lack of clout in financial negotiations have become serious challenges for some medical practices. As an example, in many parts of the country, pediatricians are no longer reimbursed the actual costs of providing children's vaccinations. So, these doctors are faced with a tough choice – lose money on every inoculation or discontinue an extremely important element of pediatric care.

Second, it has become increasingly difficult to recruit and retain new physicians. Medical recruiters note that recent graduates seek a work-life balance in their professional arrangements. In some instances, they aren't as interested in partnership tracks as they are in straight salaries. And, the increased interest in part-time employment and family leave is only partly attributable to the growing number of women physicians.

Third, the clinical demands of a medical practice are increasingly complicated. In many groups, physicians employ individuals who hold advanced clinical certifications or licenses. In numerous states, legislatures or licensing boards have expanded the scope of practice for these professionals. Often, they are able to provide levels of care that were previously limited to physicians' licenses. As a result, these employees help decrease the physicians' workload; however, they also command higher wages.

Another wage-related challenge arises out of smaller practices' inability to afford professional practice managers – skilled leaders who understand the clinical elements of practice as well as the business and regulatory functions. Without top notch administrative leadership, smaller practices may be more likely to run afoul of professional standards. From a clinical perspective, that might mean poor infection control compliance, lax clinical documentation, or inadequate customer service training – all potential professional liability exposures. From an administrative perspective, HIPAA, Stark, or other corporate compliance violations could threaten a practice with significant financial losses.

Without expert practice management, physicians may also be unable to stay current with changes in government regulations, such as: coding updates; incentives for electronic health record implementation; and the potential impact of the integration of medical practices into Accountable Care Organizations (ACOs).

Dentists also worry about whether to sell their practices.

The buy-up trend affects dentists as well. They face all of the same challenges listed above. In addition, their practices are impacted by scant healthcare plan reimbursement and high percentages of patients who defer out-of-pocket dental expenses. With lower profit margins, and overheads that can rival those of medical offices', dentists are justifiably concerned about the economy and its potential effects on their practices. The number of Dental Management Organizations (DMOs) or Dental Management Service Organizations (DMSOs) has proliferated over the past decade as some states have loosened their requirements that only dentists can own and run dental practices.

When compared with small medical practices, dental practices may struggle with additional administrative challenges. Staff salaries, overhead, and regulatory compliance pose financial burdens and decrease the likelihood that advanced degreed professionals will be hired to provide practice management services. Rather, it is the dentist who most often assumes responsibility for human resources, corporate compliance, and privacy and security – in addition to his or her clinical duties.

While none of the healthcare professions were immune to the recession that began in 2009, in response to financial losses, many dentists have felt compelled to continue working beyond a point where they had originally planned to retire. Their delayed retirements will occur at the same time that younger colleagues also begin to wind down their careers. The resultant surge in retirements, over the next decade, is expected to cause a glut of practice sales and closures. It is possible that excess market capacity may depress resale values. At the same time, forecasters predict that the number of dental retirees will far exceed the number of graduating dentists until at least 2020.[3] As a result, an interested buyer may be more attractive to a dentist who wasn't interested in selling his or her practice three years ago. It's no wonder that a recent Google search, titled "how to sell a dental practice," resulted in over 2 million hits.

Surveying the current dental market.

Dentists have reported that many of the companies currently buying up dental practices are for-profit organizations, owned by investment groups. Some dental leaders and dental societies, have expressed concerns that certain of these organizations may lack sufficient clinical leadership to ensure quality dentistry. And, occasionally, experience has shown that the clinical leader has been a mere figurehead with little or no authority to define or reinforce clinical standards. The American Dental Association urges dentists who are considering the sale of their practices to contact the ADA and take advantage of its contract advisory services – in addition to working with qualified attorneys.[4]

Today, dentists, as well as other healthcare professionals, should ask to see the buying entity's clinical and business policies, including their training and quality assurance programs. Failure to produce such documents can be a red flag. Review of policies and procedures will give the prospective seller/employee a behind-the-scenes view of the organization's values and its commitment to them.

If possible, it might be useful to spend some time observing in one of the organization's practices. By watching how the practice is run, how staff and employees interact with patients, and by noting the general "tone" of the practice, the dentist who is thinking of selling her practice to a corporate entity should be have a better sense of the extent to which a change of ownership will influence the culture of the practice.

Lessons learned: It was physician Thomas Fuller who wrote, in 1732, "It may be well to stumble; a stumble may prevent a fall." Taking Fuller's words to heart, the challenges of the practice buyout initiatives of the 1990s may improve the odds of sound decision-making for the 2000s. Whether doctors wish to retire or to stay on in some capacity with their practices, they should be better prepared today than their colleagues were ten years ago.

No one should feel rushed or pressured to accept an offer to sell a practice. Doctors should be very clear about their intention to ask questions, to confer with experts, to negotiate, and to deliberate before signing anything. Recognition of past concerns, a sampling of which is listed below, may help prevent future misunderstandings.

"Doctors should be very clear about their intention to ask questions, to confer with experts, to negotiate, and to deliberate before signing anything."

a. Failure to determine whether or not the two organizations have compatible cultures. An organization that is highly patient-centered may have a difficult time accommodating the production-focused quotas of a more profit-oriented entity. At the same time, proponents of an efficiency-focused business model may be frustrated by the seemingly disjointed business plan of a compassionate and clinically excellent practice. Each side needs to find a comfortable middle ground that comes from listening to the other party's concerns.

b. Failure to perceive that doctors can't continue to control administrative decisions once they'd sold their practices. A common example cited was their inability to protect key employees' jobs. Even when assurances were given, staff cutbacks nonetheless occurred. In some instances, the loss of employees threatened the practice's ability to provide income-generating ancillary services. In addition, staff shortages increased the risk of error, patient injury, and resultant litigation.

c. Misunderstanding the value of ancillary services. In addition to the staffing challenges that affected ancillary services, purchasers of medical practices didn't always support the ongoing provision of ancillary services; in some cases, they were eliminated, generally, for economic reasons. Doctors were upset by this because income from these services helped many practices meet their fiscal goals. Without these services patient populations drifted toward competitor groups, thus undermining patient loyalty – which purchasing entities had claimed as their primary objective.

d. Disregard for patients' feelings about changes in the practice. Patients often resented abrupt changes in practices they had long patronized and complaints and peer review actions increased. These problems were stressful for the affected physicians and dentists who felt that they were being blamed for problems they had not caused and did not have the authority to resolve. To prevent such recurrences, each party in the negotiations should share their vision of what patient care ought to look like, going forward.

e. Indifference to the fundamental importance of quality care. In the past, this commitment was often overlooked or given lip service. As one example, previous quality commitments didn't always take into account the extent of the purchasing entity's obligation to pay for the purchase, maintenance, and necessary training for equipment used in the practice's essential services. Satisfactory clinical outcomes may be challenged if the equipment used in tests or treatments is in poor repair or obsolete. Likewise, with needed supplies. One "merged" hospital practice reported that employees resorted to stealing EKG supplies from the hospital in order to complete tests that had been ordered because the hospital had not budgeted for any of the practice's testing supplies.

(Continued on page 20)

Get It in Writing: Risk Management Perspective

On the Sale of a Medical or Dental Practice and Related Employment Issues

David Jose, Esq.

The decision to sell a medical or dental practice can pose many challenges. Healthcare providers are unlikely to be experts in the array of issues that must be addressed and agreed upon, in order for a sale to satisfy the expectations of both buyer and seller.

In this article, attorney David Jose of the Indianapolis firm of Krieg DeVault shares some risk management insights about the sale of healthcare entities. His experiences provide a sampling of solutions to some of the contentious issues that can sometimes complicate sale or employment-related negotiations.

> *"When preparing these agreements, it is best to negotiate as many terms and conditions as possible, in advance of finalizing the relationship."*

Perhaps no other saying better expresses the sale of a healthcare entity than "the devil is in the details." To be aware of these details and to know how to manage them, practice owners need to engage in a learning curve. Given the wealth of potential information, and this publication's limited space, Jose's comments address four areas.

1. The role and benefits of written documents, generally: Legal contracts should generally provide a clear description of what the parties intend to do, what risks are anticipated, how they choose to allocate responsibilities and obligations, and what their expectations are when things go wrong.

The rationale for written agreements: A "handshake" or simple agreement contained in a letter or some similar document may cover the broad description of what the parties are attempting to achieve, but it will not cover all of the scenarios that can result from a single transaction or during an ongoing commercial or business relationship.

Unfortunately, examples abound of these "expectations and assumptions" that can turn sour. Here are just a few:

- When equipment in a newly purchased practice doesn't work, who should pay to fix it?
- Does the selling party have any obligation to help the purchasing party become qualified to bill third party payers? Without this assistance, the purchasing party may suffer financial loss if the approval process drags on for an extended period of time.
- If a healthcare provider leaves/sells a practice, what will happen to his or her accounts receivable? Many sellers assume, incorrectly, that this money is, in essence, their "severance."

Without written stipulations in the sales agreement, each party may have a very different view of how such matters should be resolved. In some instances, a resolution can take several years – and thousands of dollars.

Identify potential misunderstandings: As lawyers attempt to avert the kinds of problems just mentioned, their clients may conclude that they are too detail-oriented. This is because attorneys are "risk averse" and want to anticipate everything that could go wrong in a business relationship. As a result, they may appear to be obstructing or diverting the parties from accomplishing their mutual goal. However, a good legal document for a business relationship should attempt to cover as many contingencies as reasonably possible so that the parties can proceed with the focus on mutual success as opposed to wondering and worrying about what may happen if "something" goes awry.

Contracts vary. It's important to recognize this fact. The specific content of documents will vary depending on the nature of the transactions. Thus, a lease agreement will be very different from an employment agreement, which differs from a computer system or a software license agreement. However, each agreement will attempt to sort out the respective rights and responsibilities of both parties in response to anticipated, as well as unanticipated, events.

External factors will influence agreements. Signed agreements have taken on greater impact in the healthcare arena due to an array of state and federal regulatory requirements. In addition to various agreements being in place for licensure, certification, or accreditation purposes, federal laws – such as the Stark Law and Anti-Kickback laws – require written agreements that reflect terms and conditions compliant with the statutory or regulatory demands. Further, state laws dealing with the patients' rights in the transfer of care are also implicated. Such mundane issues as transfer of records to another provider, access to copies of records, and an agreement about fees for copying records can turn acrimonious without written agreements.

When preparing these agreements, it is best to negotiate as many terms and conditions as possible, in advance of finalizing the relationship. Once the relationship has begun, the relative leverage of the respective parties may become distorted. Doctors selling practices today are often negotiating with much larger organizations, and may be inexperienced in contract negotiations. Whereas, large entities may have considerably more experience in negotiations and may be able to use that experience to better protect themselves from proposed changes in the agreement.

For example, the less powerful party in the negotiations might be told, "Oh, we're sorry but standard practice is not to compensate for those ancillary services that your office has provided." Once the less powerful party is aware that this may simply be a negotiation technique, the playing field becomes a bit more level.

Occasionally, the selling party may think it best to "lie low" and not raise certain issues for inclusion in an agreement. Almost any lawyer will respond that a lawsuit is a very expensive means of attempting to enforce undefined contractual obligations. A lawyer will also warn that it can be very difficult to predict the outcome of this type of lawsuit. As a result, time and resources are better used by clarifying expectations resolving remote possibilities, and allocating rights,

responsibilities, and obligations. Here is an example of an informal obligation that led to legal battles:

A sale was finalized and, soon after, the corporate entity was audited. In order to respond appropriately to the audit, the organization needed the former employee/partner/associate to help provide "reasonable assistance." Without that individual's input, important concerns could not be addressed and the organization's actions were left open to negative interpretation. In such an event, a few actions interpreted negatively could have been extrapolated to the entire records population, potentially exposing the entire corporate entity to fines and/or penalties. If no agreement to assist was part of the original contract, the former employee may have no legal duty to invest time or effort on the organization's behalf.

2. Legal issues to be documented when joining or leaving a practice as an employee or partner: A number of both major and minor issues must be addressed when a healthcare professional intends to join a medical or dental practice as an employee or partner. Similar considerations apply when a potential new employee or new partner is being evaluated. Common issues that receive most of the attention include, but are not limited to: compensation, hours, resource support, continuing education, call coverage, and relocation expenses.

Restrictive covenants: Perhaps not as well understood, but commonly included in legal agreements, are negotiations related to restrictive covenants. These are often referred to as non-compete agreements. In addition to restrictions that limit the geographic area where a provider may move his or her practice, a restrictive covenant may also prevent the physician or dentist from offering jobs to key employees. Or, it might forbid the party leaving the practice from sharing or benefitting from proprietary or confidential information associated with the previous employer.

Restrictive covenants are often misunderstood and, as a result, may be pronounced as settled truths. Unfortunately, the misinformed may believe that terms and conditions surrounding a restrictive covenant are not negotiable. Or, they may pursue a strategy of hoping that the covenant will be unenforceable. This confusion highlights the importance of negotiating all of the material terms of a contract – even when one believes that the other side won't propose any changes. Discussions of what is "fair and reasonable" can be valuable because often they reveal conflicting scenarios and opposing perspectives, thus enabling the parties to resolve misunderstandings.

"Discussions of what is "fair and reasonable" can be valuable because often they reveal conflicting scenarios and opposing perspectives, thus enabling the parties to resolve misunderstandings."

Subrogation clauses: Although not common, subrogation clauses should be considered. They may occur, for example, where both parties purchase some sort of business-related insurance and, when a loss occurs, it is unclear if one or both parties have agreed to transfer the loss. At a minimum, if one party purchases insurance, they should seek expert advice if asked to sign a document relating to subrogation of rights, which may mean that they are signing away their rights, and possibly the rights of their insurer.

Terminating the relationship: While still considering whether or not to join a practice, it is also wise to consider "exit strategies." This cautionary approach may seem unnecessary to some more optimistic individuals. Nevertheless, it is a sound professional consideration to define the circumstances that might necessitate the termination of the relationship – and to determine the associated financial ramifications.

Both parties need to discuss the circumstances that might allow – or require – termination of the relationship. If, for example, clinical incompetence or disruptive behavior is named as a potential dissolution factor, it should be identified and addressed within a formalized framework which utilizes:

a) A fully functioning peer review program;
b) A general listing of inappropriate actions or behaviors that provide an overview of generally unacceptable actions – but does not act as an all-inclusive list; and,
c) A team of individuals who are qualified, authorized, and accountable to manage and resolve such conflicts – and who function independently of the parties involved in the dispute.

Aside from the conflict of personalities, other challenges with regard to terminating the relationship should also be considered and planned for, including:

- What barriers might preclude moving to another practice site and how might the termination of the relationship play out if it occurs early on in the relationship as opposed to a number of years down the road?
- What might happen if regulatory or compliance actions or lawsuit claims are threatening the practice at the time of termination?

These are the types of scenarios that need to be foreseen and fleshed out in order to fairly and adequately negotiate a written employment agreement.

3. Selling a practice to a large system: There are many circumstances under which a healthcare professional (or the group within which he or she practices) may sell a medical or dental practice to a larger system. When that system is a nonprofit and tax exempt organization, many limitations may be imposed on the financial terms and conditions of the relationship. When the system is a for-profit organization, the professional must recognize that he or she

will be joining an organization that needs to deliver a return on its investment to outside investors. As a result, production requirements should be an important topic of discussion.

In addition, state and federal laws such as the Stark requirements and Anti-Kickback laws also impose constraints on the nature of the transaction and the valuation of the practice.

Financial compatibility: The sale of a practice to a large system or corporation may pose additional difficulties for practitioners if the purchasing entity doesn't understand office-based billing. As a result, doctors who continue to provide the same services may be dismayed by the negative impact on their reimbursements. It's better to identify the potential for such problems before contracts are signed and time-consuming workarounds are needed. A comparison between the billing processes of the existing practice and the potential buyer may help prevent a vexing – and financially draining – challenge to the practice that has been acquired.

One of the current issues facing solo or small group practitioners is the push toward electronic medical records and data systems. Financial incentives and the promise of administrative efficiencies drive this issue for larger systems. This pressure may prove stressful for the physician or dentist coming out of a solo or small group setting. The financial consequences that may accompany these decisions should be identified and addressed since investments in clinical or administrative resources may expand the overhead burden with negative results, e.g., a depressed compensation formula or the imposition of onerous time demands.

Compare cultures. Given the current economy and the state of healthcare in general, many might believe that valuable benefits can be gained by joining a larger system with respect to the availability of resources and managerial or administrative support. Part of the negotiation process is to discover the reality of that support – and how it will actually play out for the professional practice of the individual. What policies and protocols will be imposed on the providers and staff? What limitations or constraints will be in place? What are the implications of joining a system that has a more bureaucratic quality assurance and/or performance improvement philosophy? What is the tolerance or response to patient complaints or to complaints about disruptive behavior in the larger setting as opposed to the smaller practice?

"Negotiable" vs. "non-negotiable:" The sale of a practice to a larger system or organization also can result in the loss of control as to the location or the type of practice. These shifts may extend to staffing arrangements, clinical policies, referral relationships, and committee demands. The negotiation process should attempt to clarify as many of these clinical and administrative features as possible. Again, while many such issues may be "non-negotiable," defining the "essentials" can help clarify everyone's expectations for the potential new relationship.

4. Leadership transitions: Some of these issues may be addressed through a process of selling one's practice or otherwise making arrangements with another professional group or larger system. Often, this process is done as part of a transition and the physician or dentist taking over the practice will want the retiring professional to continue in some capacity in order to facilitate the transition of goodwill to the new buyer. This requires careful delineation of rights and responsibilities under this new arrangement. (See *Now That the Practice Has Been Sold…* on Pg. 18)

Surrendering control: It can be difficult for a long-time professional to surrender control over operational and clinical issues. Arrangements should be made to ensure that the retiring physician's or dentist's responsibility for health records, insurance coverage, third party payer communications, audit responses, and other matters are clearly delegated.

Further, selling a practice may include special arrangements for installment payments or payments tied to collections after control of the practice has been delivered to the new provider. This needs to be done in a way that the retiring professional's payments are not threatened by inadequate collection efforts or payment disputes. Anticipating effective enforcement rights can be a difficult process and may require the skill of qualified experts – attorneys, accountants, business, or financial advisors.

When both parties have documented the respective rights and responsibilities and appropriate protections, a more diligent effort to follow through and fulfill the contractual obligations often results. The retiring professional's cooperation and assistance can be an essential element in dealing with the effective operation of the practice by the new professional, and this can also be an important way to monitor and satisfy any retrospective audits or investigations that might take place relating to activities undertaken in the prior practice.

Conclusion: The sale of a medical or dental practice can be a challenging undertaking. With sound advice and the expertise of qualified professionals, the doctor has a better chance of determining whether or not a sale – or a sale to a particular buyer – is the right decision. Having gathered the relevant information and having fully engaged in necessary discussions and negotiations, the hard work is more likely to pay off in a positive way. ■

David E. Jose, Esq., is a partner with Krieg DeVault, LLP. He concentrates his practice in health care, corporate, administrative, and regulatory law. He handles regulatory compliance and administrative appeals, contract review and negotiation, business transactions, and general commercial and corporate legal matters for for-profit and nonprofit health care and general business organizations and individuals.

Selling Your Practice? What About Your Insurance?

To sell – or not to sell: Thinking about selling your medical or dental practice? One of the many issues you'll want to discuss with a potential buyer is your professional liability insurance. Following is a list of questions that doctors may want to include in their deliberations about whether or not to sell a medical or dental practice:

1. Will my new employer pay for my insurance? And, if so, what policy type will they buy?

It's important to ask this question because some employers will indeed purchase your insurance. But, if you have always had occurrence insurance and your potential employer wants to provide claims-made insurance, then you need to have a discussion about what this change in coverage will mean for you at purchase and over time.

" Obtain and review a copy of your policy, so that you understand your coverage. Check to see if you, or your employer, have been named as an insured. This will often clarify who has the right to settle a claim."

As you may know, occurrence policies provide coverage for claims arising out of incidents that occur during the policy period, regardless of when a claim is actually made. In contrast, claims-made policies provide coverage for claims made during the policy period; however, once the policy period ends, coverage also ends – unless an extension contract endorsement ("tail coverage") is in force, based upon the policy provisions. Without securing tail coverage, you will have no coverage for claims made after termination of the last claims-made policy. Tail coverage can be very expensive. If you leave this new employer, or retire, your employer may not pay for your tail coverage, unless they have previously agreed to do so, in writing.

2. If I prefer to have an occurrence policy, can I pay the difference in cost myself?

Occurrence policies are increasingly rare in today's professional liability market, largely because of the challenge carriers face in projecting the long-term costs associated with claims that may be reported long after the end of the policy period. However, if it is available from your carrier in your state, you might negotiate in an attempt to have the employer pay for occurrence coverage outright, or at least to allow you to pay the difference. Whatever the arrangement, the agreement should be in writing.

3. Can I continue to be insured by Medical Protective?

Possibly, depending on the agreement you have with your employer. The risk for you is that some employers may not fully understand the differences in carriers and the types of services they provide. Further, depending on the employer, they may choose to self-insure.

4. Will I still have the right to decide whether or not I want to settle a claim or fight it in court?

If your employer pays for your malpractice insurance, they may reserve the right to consent to settlement without your input. Alternatively, they may have purchased a policy whose provisions: a) allows the carrier to settle without consent, or b) might impact you financially if you determine you do not want to settle.

You will want to ask about their policy before you sign an employment contract so that you understand the potential risk exposure. For example, the decision to settle a claim with a financial payment may seem a shrewd financial decision to your employer. However, they may not fully understand that their decision might put you in the difficult position of having to report a malpractice claim every time you apply for privileges, purchase insurance, or join a new practice for the rest of your career. In addition, your name may be reported to the National Practitioner Data Bank and, depending on the nature of the settlement, your insurance rates may be affected.

5. Do all insurers offer risk management services?

Not all insurance carriers provide risk management services for their insureds. Ask your potential employer if the carrier they use offers: risk management consultation, informational programs and updates, and accredited Continuing Education (CME or CDE) courses.

6. Once I'm an employee of a hospital or a DMO, isn't my insurance their obligation?

While it might be their obligation under your contract, they may not always be thinking about your best interests. Over the years, Medical Protective has seen instances in which doctors have been told that their insurance has been purchased – but an oversight occurs and, without his or her knowledge, the doctor was practicing without coverage.

Obtain and review a copy of your policy, so that you understand your coverage. Check to see if you, or your employer, have been named as an insured. This will often clarify who has the right to settle a claim.

And remember that, even after you leave this employer, you will want to retain a copy of your occurrence policy or your claims-made policy – as well as your tail coverage endorsement – so that you have the peace of mind of knowing that you do indeed have coverage for the services you provided while in the employ of that corporation.

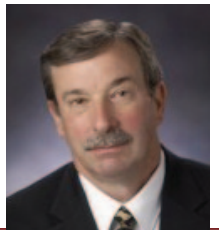
7. Any other questions that I should ask?

Another concern that you might want to explore is the inclination of some insurance companies to withdraw from the professional liability insurance line whenever market conditions harden. This "jump in-jump out" business policy can make it difficult, and expensive, for those doctors who have lost their insurance, to find new carriers without any interruption in coverage.

Conclusion: These are just a few of the reasons why your professional liability insurance is an important topic of conversation with a potential employer if you are considering selling your practice. ■

Transfer of Records When Selling or Closing The Medical or Dental Practice

Theodore Passineau, JD, HRM, RPLU, CPHRM, FASHRM



The Case

After 35 years of successful practice, Dr. Evans learned that he had cancer. Even though the cancer was aggressive, the prognosis was good and he was advised to plan for comprehensive treatment that would extend over several months. Given the circumstances, Dr. Evans decided that it was time to retire and concentrate on his health issues.

Dr. Evans retained the services of a broker who specialized in the sale of healthcare facilities and, fortunately, the sale was quickly completed. Following the closing of the sale, Dr. Evans handed the purchasing practitioner the keys to the practice – which included access to all of his patient records.

Approximately eight months later, while in the midst of chemotherapy, Dr. Evans received an unpleasant surprise. He was being investigated by CMS for a HIPAA violation filed by one of his former patients. Because he had, in fact, improperly transferred his patient records to the purchasing practitioner, the case was deemed indefensible and CMS imposed a fine which Dr. Evans paid himself since the action was not covered by his professional liability insurance policy.

Introduction

This scenario is hypothetical, but the situation it describes is not. In fact, it is not uncommon for Medical Protective's risk management consultants to receive calls from physicians or dentists who are selling their practices and, at the eleventh hour, discover that they cannot simply hand over their patient records to a purchasing practitioner or entity. Obviously, this unexpected turn of events can jeopardize the entire sale/purchase process.

The Privacy Challenge

Most physicians and dentists are aware of the requirements to protect patients' personal protected health information (PHI) as specified by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Yet, many are not aware that individual states may also have privacy regulations, some of which are more stringent than the national regulations.[1]

Generally, HIPAA mandates that the practitioner (as the actual owner of the physical record) has a duty to maintain the confidentiality of each patient's PHI. The PHI can be released only with the patient's written permission or under certain specified circumstances. Examples of these circumstances include: a) a court orders enabling police/agency investigations, e.g., death or child abuse investigations; b) public health needs, e.g., such as infectious disease tracking; or c) statistical purposes, e.g., epidemiological studies conducted by the CDC.

HIPAA also allows for the exchange of PHI without a written release between *current and prior, or contemporaneously treating practitioners* (including practitioners who are treating the patient at the same time, such as consultants). However, it does not permit the handover of PHI from one doctor to another, without the patient's written permission, when a practice is being sold, e.g., Dr. A sees patients through Friday and Dr. B takes over on the following Monday). Under these circumstances, Dr. A does not know if all of his/her former patients are going to treat with Doctor B. For this reason, Dr. A cannot just hand over patients' confidential records to Dr. B. Ultimately, while just handing the records over to the purchasing practitioner or corporate entity might seem like the most expedient solution, it just isn't permissible under HIPAA.

State statutes and administrative rules may further complicate the process. Independently, states can require physicians and dentists to maintain patients' records for specified periods of time, dating from the last date of treatment. HIPAA does not diminish the authority of these laws. Many states impose a seven-year record maintenance requirement – although there is significant variation among the states and differing lengths of time depending on the types of records and the reasons for their preservation. Also, many states impose separate, and often more rigorous, requirements for the retention of pediatric medical and dental records.[2, 3]

"Doctors should be very clear about their intention to ask questions, to confer with experts, to negotiate, and to deliberate before signing anything."

Relative to records retention requirements, most retiring practitioners choose one of two options: First, they may store the records themselves. Most physicians and dentists retiring today do not have their records in electronic formats. When this is the case, the physician or dentist who sells a practice often assumes responsibility for storing the paper records. In addition to the space requirements, this approach can be problematic if the records have not been maintained in an ordered system and a former patient requests a copy of the records – to which they are entitled under HIPAA.[4]

A second document maintenance option is the contracted services of a records storage company. While these companies' fees may be substantial, they also offer several advantages. First, they will pick up the records and store them in a climate-controlled facility – which can protect them from environmental damage, e.g., dampness, mold, vermin, etc.

As a second benefit, these companies are usually bonded or insured, thereby reducing a doctor's personal liability exposure if stored records are damaged, destroyed, or stolen while in the records storage company's possession.

A third benefit to records storage services is their ability to respond to patients' requests for records. Patients can be referred directly to the storage service, which then will locate and copy the records and collect the fee from the patient (HIPAA allows a reasonable fee to be charged for location and copying).

Finally, a records storage company will execute a legal document with the storing practitioner called a Business Associate Agreement (BAA). This HIPAA-required document obliges the storage company to protect the confidentiality of PHI contained in the patient records – to the same standard

that the practitioner must protect it. Through the BAA, the practitioner and the patient are assured that the PHI will be secure.[5]

Helping patients and their records "stay" with the practice

Experience has shown that, when a practice is sold, most (but not all) patients stay with that practice and continue their care with the purchasing practitioner. This potential for continuity is a convenience for patients and it also enhances the value of the practice. It would be ideal if patients' records could stay on site and be immediately accessible to the new practitioner – without the worry of HIPAA violations. One possible solution follows.

State records retention regulations generally do not specify how the records are to be stored; they require only that they must be maintained for a specified time. Similarly, HIPAA does not dictate how PHI contained in patients' records must be protected. Rather, HIPAA states that the owner of the record (the practitioner who created the record) has a duty to protect this confidential information. Nothing in HIPAA prevents the purchasing practitioner from becoming the custodian of the selling practitioner's records – if certain steps are followed.

Because most patients opt to stay with the practice, it can make sense for the purchasing practitioner to agree to retain the records on site, essentially providing storage services for the selling practitioner's records. To facilitate the agreement, seller and purchaser enter into a contractual agreement which specifies, among other things, that the purchaser will provide the seller with access to the physical record upon reasonable notice (such as two business days), and that the purchaser will not release or dispose of any original records without the seller's written permission. As a part of this process, it will be necessary for seller and purchaser to execute a BAA, which helps ensure compliance with HIPAA's requirements.[6]

Once these agreements are finalized and the transfer of the practice is completed, the purchasing practitioner stores the seller's records on site. As needed, patients who continue their relationship with the practice will be asked to complete a written release of the record from the seller to the purchaser. Once this release is signed, the purchaser (who is in physical possession of the record) can utilize the record as they would with any other active patient. Records of patients who leave the practice should ultimately be removed from the active files and placed in storage.

Conclusion

While it may seem onerous, HIPAA has been valuable in providing uniformity in administration, and enhanced protection, of patients' PHI – and this is an important consideration in this age of medical identity theft. With proper planning, the practitioner wishing to sell his or her practice can accomplish the goal of providing continuity in ongoing patient care and, where necessary, the transfer of patient information, while at the same time fully complying with HIPAA's requirements. ■

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FOOTNOTES

1. It is important to be mindful that, while many state privacy laws end their jurisdiction at the time of the patient's death, HIPAA does not. Following the death of a patient (such that they can no longer authorize the release of their PHI), usually the only person who can authorize the release of the PHI is the executor or personal representative of the deceased's estate. If an estate does not exist, a court order may be required to authorize the release of the information.

2. It is important for the practitioner to know exactly what the retention requirements are in their state of practice. This information can normally be acquired through the state medical or dental society.

3. This article discusses only risk strategies for record retention. The retiring practitioner should also consider that it still is possible to be sued for malpractice, after retirement. If this occurs, it is critical that the record be available to facilitate the defense of the case. Further information which explains Medical Protective's recommendations for record retention can be requested from MedPro's Risk Management Department.

4. Under HIPAA, the practitioner's responsibility to provide patients with copies of their records does not terminate with the practitioner's retirement. As long as the practitioner still possesses the record, he or she must provide a copy to the patient if requested.

5. This article focuses on the practitioner who is still using a paper record system. If the practitioner has transitioned to an Electronic Healthcare Record (EHR) prior to the doctor's retirement, then PHI transfer is less complicated. In such cases, the retiring practitioner would simply obtain the proper authorization from the patient and then transfer the appropriate PHI, in an encrypted format, to a free-standing hard drive, which would then be given to the purchasing practitioner. The selling practitioner could also maintain a copy of all of this information on a freestanding hard drive. Transfer of the data to the purchasing practitioner would, of course, still require the execution of a BAA.

6. The BAA is designed to protect the selling practitioner from liability for the improper release of PHI which is now in the possession of the purchasing practitioner. Doctors should discuss their plans to retire and/or sell the practice with their Medical Protective sales representative or their independent agent. This discussion should help ensure that the doctor has coverage for those rare instances in which a liability action is filed, even after the insured's retirement or death.

Now That the Practice Has Been Sold – Let's Prevent Some Common Snags

Mario Catalano, DDS, MAGD

Sometimes the complications related to the sale of a dental or medical practice don't occur until long after the ink is dried on the purchase agreement. Simple misunderstandings can turn into serious disagreements. To prevent problems, buyer and seller need to agree, in advance, how they will handle certain situations.

Clinical issues

The continuity of patient care is often an issue when a medical or dental practice is sold. One common example occurs when treatment completed by the seller deteriorates after the sale of the practice, and the seller is no longer involved with patient care.

A retiring doctor puts on a crown and shortly thereafter sells the practice. Nine months later, the porcelain on the crown breaks.

The patient returns to the practice and is examined by the new owner who determines that the work should be redone. Who's obligated to take care of the situation? A pre-existing agreement should determine both who is financially responsible for the costs associated with the repair, and who is responsible for the treatment. Typically, the buyer is responsible for proposing a new treatment plan to the patient.

Without this type of agreement, the new owner may feel that his only recourse is to tell the patient, "Your crown failed; it needs to be replaced. The cost is going to be $1000.00. You should contact Dr. A and try to collect from him." In fact, this response implies that the patient may have to pay for the same work twice. It could be an open invitation to a lawsuit. Also, it places the challenge of resolving the matter on the patient, potentially making the patient feel that he or she must pit one doctor against the other.

Instead, by pre-existing agreement, the seller and buyer should have worked out the details of how they would handle this type of situation. One preferable arrangement would be for the parties to put a certain amount of money into an escrow account and mutually agree that each/both can make withdrawals according to the provisions of the agreement.

In the case of the damaged crown, the doctors could have discussed the matter and agreed who will pay for it, out of the escrow account. This would keep the patient from being caught in the middle of a disagreement that might become quite contentious. If the patient begins to feel that the doctors are playing tug of war with him, he may say, "This is baloney! I need additional treatment and I've got pain and suffering. I want the tooth repaired and I think I'm entitled to some money, too!"

Practice continuity

The purchase of a practice (medical or dental), requires a lot of money. In some instances the facility may need refurbishment and some of the equipment may be functioning only marginally. Generally, the purchaser benefits more from the goodwill of the existing patients than from the tangible aspects of the practice – equipment, supplies, etc. Therefore, it's important that the parties agree, in advance, how repair and replacement issues will be managed. Without this agreement, the selling doctor may be surprised to discover that the purchaser expects him to pay for several expensive repairs. And, the doctor who has purchased the practice may have assumed that everything will be in peak working order. It's easy to see how bad feelings can result if each party has completely different expectations.

Building patient trust

To reiterate, the most valuable aspect of the sale may well be the retention of satisfied patients. From a business retention perspective, the practice may suffer significant financial loss if a number of patients need work repaired by the new owner. On the other hand, if no one steps up and makes good on work that really should be replaced or repaired, word gets around. A patient may go elsewhere, but not before sharing his displeasure with others in the community. The departure of one influential patient may trigger a sizeable exodus.

"The parties should have their personal attorneys participate in the negotiations to ensure that, when the deal is done, there are no unpleasant surprises for either party."

This loss can be devastating. Further, if existing patients were already thinking about changing providers, the ideal time to do so is when the practice is changing hands. So it's especially important for the new doctor to establish positive relationships – with staff as well as with patients – in order to attract new clients as well as to retain existing business.

Often, it may take some time for patients to get used to the new owner. He may not be as experienced as his predecessor so it's important that he be at least as popular. If the patients are satisfied, then everybody wins. If, on the other hand, they don't like the new owner as well as the previous owner, they may make a move. So, while he may do some replacement work for the sake of customer satisfaction, it's not a good idea for replacement of the previous owner's work to be seen as a profit motive for the new owner.

Conclusion

The sale contract is an important component of satisfaction for both seller and buyer. The parties should have their personal attorneys participate in the negotiations to ensure that, when the deal is done, there are no unpleasant surprises for either party. Discussions of possible areas of contention, the establishment of an escrow account, and legal review by qualified attorneys will help keep everybody on the same page. ■

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Back to the Future: Another Round of Practice Buy Ups

(Continued from page 5)

f. Lack of familiarity with proper billing for physicians' services. Billing errors caused reimbursements to plunge, especially in hospitals where ancillary services associated with newly-acquired practices had not been available previously. In today's regulatory environment, erroneous billing submissions might easily cause a medical specialty practice to be swept up in a RAC audit.

g. Assumptions that medical practices can be managed in the same way that hospital departments are managed. Advance knowledge about that incorrect assumption provides today's doctors with valuable talking points to ensure that both parties have a better handle on management solutions that are fair to all.

A handshake is not a contract.
Today, physicians, dentists, and other healthcare professionals can benefit from lessons learned during the practice buy-up transactions of the 1990s. More information and resources are available for healthcare professionals than existed ten years ago. As a result, doctors can be better prepared, ask more questions, and use the negotiation process to effect satisfactory results for all parties.[5]

Conclusion:
Physicians and dentists who are thinking about selling their practices, should map out a list of considerations, including:

a) their actual reason/s for wanting to sell;
b) if, rather than a sale, they really need expert assistance to get the practice back on track; or c) they'd be better served to buy out or merge with another practice, giving themselves more financial clout, negotiation power, and lightening the work load.

" Handshake deals and verbal commitments are a leading cause of disputes between the parties – and they rarely stand up in court."

If a sale is desirable, then they need expert advice about how to negotiate an agreement that best meets the needs of all parties. Handshake deals and verbal commitments are a leading cause of disputes between the parties – and they rarely stand up in court. By doing their homework on the front end, physicians and dentists stand a better chance of achieving satisfactory practice arrangements, regardless of the format of the practice. ■

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