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Physician Credentialing in Managed Care

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I. INTRODUCTION

Managed care has been a part of the American healthcare system for a long time. Programs and entities that were prototypes for what is now called "managed care" have been in existence for at least 60 years.[1] Only since 1970 has this form of healthcare plan truly flourished with not only a greater spread geographically, but with a twenty fold increase in the number of programs and over an eight fold increase in enrollment.[2]

As managed care's role in the healthcare system has increased, more attention focuses on the selection of healthcare providers for these programs.[3] This process of selecting providers in managed care programs involves "credentialing," the review of the qualifications of providers, especially physicians, for inclusion on the panel of providers.[4] Credentialing in managed care is not without controversy. Questions are raised about the effectiveness of credentialing given the practical and logistical problems in collecting, verifying, and scrutinizing credentialing information.[5] In addition, practitioners excluded from participation may attack the credentialing process on antitrust and other grounds.[6]

The public has shown a great enthusiasm for managed care programs, with the percentage of consumers in any given market en-

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* This article is adapted from a speech given by Mr. Bloom.

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1. PETER KONGSTVEDT, THE MANAGED HEALTH CARE HANDBOOK 4 (1989).
2. ROBERT SHOULDICE, INTRODUCTION TO MANAGED CARE 29 (1991).
3. NATIONAL HEALTH LAWYERS ASSOCIATION, THE INSIDER'S GUIDE TO MANAGED CARE: A LEGAL AND OPERATIONAL ROADMAP 117-118 (1990) [hereinafter INSIDER'S GUIDE].
4. Mike Mitka, *HMOs Scrutinize Doctor Credentials*, AM. MED. NEWS, July 27, 1992, at 13, 14.
5. Alan Bloom, *The Malpractice Minefield*, MANAGED HEALTHCARE, Sept. 11, 1989, at 27.
6. *See, e.g.*, Capital Imaging Assocs. v. Mohawk Valley Medical Assocs., Inc., 725 F. Supp. 669 (N.D.N.Y. 1989); Northwest Medical Lab., Inc. v. Blue Cross Blue Shield Or., Inc., 794 P.2d 428 (Or. 1990).

rolled in such programs increasing. Enrollment in these plans has grown in part because of the promotion of these plans by employers. Thus, physicians who are not selected, or elect not to join managed care organizations, feel the economic pinch. As managed care programs continue to tighten their credentialing requirements, physicians excluded from participation will feel increasing economic pressure, and can be expected to take legal action. It is thus imperative that managed care programs carefully design credentialing programs to utilize objective criteria that can be defended in these actions.

Managed care programs must credential both individual providers and the provider organization as the quality of both directly reflects on the managed care program. In addition, as discussed below, a managed care program may be liable for the conduct of those with which it contracts. This article will explain and assist with the credentialing process in the managed care setting.

II. Managed Care

The term "managed care" represents a wide range of medical programs that combine both insurance and health delivery within a unified framework. In the health insurance system, patients locate and contract directly with the physician. The only task for the carrier is to review the bill and determine whether to pay the provider. Unpaid bills become the responsibility of the consumer. In the managed care system, the managed care organization is responsible for locating and compensating the provider of the medical care. In most managed care organizations, the provider is an independent contractor and not an employee of the organization. The provider often dictates the managed care program's survival. Thus, it is prudent business practice for the managed care program to evaluate, through the credentialing process, the practitioner with whom the program contracts to deliver medical care.

III. What is Credentialing?

The term "credentialing" can be defined as the process of verifying and reviewing a provider's evidence that he or she should be given the right to hold a particular position. Managed care credentialing is determined by respective plan policies, unlike hospital credentialing, which is determined by state law and the Joint Commission on Accreditation of Health Organizations policies. Credentialing involves a review of relevant information such as educational background, licensure, work experience, board certifica-

tion, staff privileges, and references. This review should be conducted at the recruiting stage as well as on a regular basis, such as annually, to assure that the provider is still appropriate for the organization.[7]

The primary consideration in the credentialing process is the provider's "cooperation." A managed care program is an organized health care delivery system. Thus, while providers are expected to use their own medical judgement for care decisions, they must follow numerous "rules of the road." For example, the provider must obtain pre-approval for hospital care, and must follow the utilization review committee decisions on care requested by a patient/member. The managed care program has certain coverage and payment rules, and various approvals and authorizations are required before care is to be delivered. It is the responsibility of the physician to learn of and follow these procedures. Thus, a physician who does not desire to follow these procedures of the managed care setting or who degrades the health plan as inferior should not be a part of the health plan. A provider may give quality medicine and may be an excellent practitioner, but if that provider refuses to cooperate with the health plan and follow its basic rules, then the program will have to consider removing that provider from the plan.

Cooperation credentialing is applicable to all managed care programs. However, as explained below, most credentialing methods are determined by the relationship between the program and its providers.

IV. Provider Relationships and the Effect on Credentialing in Managed Care

Managed care programs differ based on organization form, sponsorship, and the method for the delivery of health care services. For the purpose of exploring the differing approaches to credentialing, the relationships between managed care programs and providers can be grouped into three major categories.[8] These three categories are (1) programs that employ providers, (2) insurance programs responsible for obtaining insurance for their providers, and (3) programs that contract with independent practitioners.

The first category of managed care programs must thoroughly credential since the program is employing the practitioner. The

7. Shouldice, *supra* note 2, at 191-192; Kongstvedt, *supra* note 1, at 42.

8. This article will focus on physicians, although the concepts are substantially applicable to other health professionals.

practitioner must submit an employment application containing his or her education, background, expertise, and references, all of which must be verified. The program needs to inquire of the National Practitioner Data Bank,[9] although such inquiries will yield little information until the Bank had been in operation for some years. This is traditional physician credentialing, similar to that performed in the hospital setting for medical staff members.

The second category of managed care programs, those that in addition to hiring and supervising physicians provide malpractice insurance to their providers, employ a more substantial credentialing process. In addition to traditional credentialing, described above, the program must obtain for each physician a loss history and information of all professional litigation in which the physician has been a defendant. Although the physician is often asked to submit this information, letters should be sent to previous employers and previous insurers requesting this information.[10] In addition, the National Practitioner Data Bank must be queried to verify the information provided by the physician and other sources.

The third category of managed care programs contract with independent practitioners; they do not provide malpractice insurance for their practitioners and do not employ or control the medical group. Thus, managed care credentialing should involve the verification of malpractice insurance, which verification should be conducted annually. This verification is very important. If a physician is uninsured, the managed care program is more likely to be targeted as a defendant by an attorney filing a medical malpractice action seeking sufficient resources to pay a potential judgement.[11] A managed care program neither employing nor insuring a physician with hospital privileges need only confirm medical malpractice insurance since the physician's credentials were verified by

9. U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, NATIONAL PRACTITIONER DATA BANK GUIDEBOOK (1990). Established by the Health Care Quality Improvement Act of 1986, the National Practitioner Data Bank contains information of claims made against licensed physicians. *See* 42 U.S.C.A. § 11131-11137 (West Supp. 1992).

10. Credentialing for both employment and insurance purposes in the medical setting generally requires information regarding the following activities: (1) criminal convictions, (2) state medical and narcotic licensure status, (3) drug use history, (4) licensing authorities actions, (5) area of practice, including the percent of practice devoted to surgery (especially for insurance rating purposes), (6) board certification and eligibility, (7) hospital privileges, (8) history of current and previous malpractice insurance, (9) medical school and other professional training including internships and residences, and (10) continuing medical education attended in recent years.

11. John Horty, *Acceptable Criteria for Appointment & Clinical Privileges, in* HOSPITAL LAW, MEDICAL STAFF APPOINTMENT AND CLINICAL PRIVILEGES 8 (1988).

the hospital. In addition, many physicians are members of medical groups, and most groups perform extensive credentialing.

With regard to all three categories of programs, situations may exist where additional credentialing or inquiry is mandated. If a physician has a poor reputation in the community or a record indicating poor quality of care, the managed care plan must exercise caution in contracting with that provider. A court may hold a plan liable for the actions of its independent contractor when such contractor has a history that indicates quality problems.[12] The managed care plan must carefully design its credentialing process.

V. NEW CREDENTIALING TREND: HEALTH CARE DELIVERY

Designers of credentialing programs must focus on the operations of the providers, since managed care should use credentialing to assure that it can meet its most important responsibility, arranging for healthcare services. The managed care program contracts with a member, and directs the member to its contracted providers who actually deliver the medical care. The managed care program typically does not control the healthcare facilities, and may not know if those facilities are open and properly staffed. Managed care programs should focus on this problem when credentialing.

The managed care program's contracts with its independent practitioners should set forth the facilities the practitioners will utilize; the facilities' hours of operation; the manner in which the facilities keep medical records and adhere to various other standards; and the manner in which the contracted professionals will

12. *See also* Stelmach v. Physician's Multi-Specialty Group, No. 59306 (Mo. App. June 13, 1989).

A managed care plan also may be found liable for the improper credentialing of its independent contracting physicians. Some courts that have recently examined managed care programs' responsibility for the acts of their independent practitioners have upheld a cause of action, *see, e.g., Boyd v. Albert Einstein Medical Ctr.*, 547 A.2d 1229 (Pa. Super. Ct. 1988), while others have not, *see, e.g., Raglin V. HMO Ill., Inc.*, 595 N.E.2d 153 (Ill. Ct. App. 1992). The cases decided to date, however, are focused on ostensible agency theories, not on credentialing or negligent entrustment theories. When negligent entrustment is raised, it is one of many causes of action and the courts provided little direction in what constitutes proper versus improper credentialing. For example, in the recent decision of *McClellan v. Health Maintenance Org. Pa.*, 604 A.2d 1053 (Pa. Super. Ct. 1992), the plaintiff claimed the HMO was liable for the acts of its independent contract providers based upon the theories of ostensible agency, corporate negligence, breach of contract/breach of warranty, and intentional misrepresentation/fraud. The court held the plaintiff stated a cause of action under each of these theories. With regard to the negligent entrustment/credentialing theory, the court established a "reasonable care" standard for the selection of providers.

arrange for around the clock care. The program should put its efforts not into verifying the medical credentials of these providers, but rather into verifying that these criteria are met. Program staff members should visit the medical groups and offices of the individual physicians with whom the program contracts to assure that they exist and operate in an appropriate manner, and to check medical records, overall cleanliness, and facilities' hours. In addition, random calls should be made to the provider to see that patient calls will be answered at all hours. The program should have a grievance procedure for consumer complaints and should investigate complaints about specific providers and facilities, with special attention given to allegations that care is not available around the clock.

With these mechanisms in place, the managed care program can assure its members that its healthcare professionals provide services that are *available*, *accessible*, and *acceptable*. A full complement of health professionals and facilities should be *available* for program members when the need arises. The staffing patterns of contracting medical groups and the services available at contracting institutions should be monitored. If a medical group loses its obstetricians, for example, the program needs to work with the group to assure these services remain available.

Health services must be *accessible*, that is available in a timely manner. The time it takes to obtain appointments, the waiting time for appointments, and the waiting time for urgent and emergency services should be monitored. A program may have to stop enrollment at a particular group or individual provider if additional members would overload the ability of that provider to keep services accessible.

Acceptable services are those that fulfill the members' expectations. Medical offices should appear professional to the members; offices that are dirty, look shabby, or otherwise present an unprofessional appearance do not meet members' expectations.

Managed care plans must not only view the credentialing process from the aspect of providing health care, but also from the aspect of the exclusive nature of the managed care plan.

VI. Exclusivity in Managed Care

Any discussion of credentialing in the managed care setting raises the question of exclusivity between a particular provider and a plan. It is a fundamental staffing question, even though it is not raised as a credentialing issue in most managed care settings.

Managed care programs are either open or closed panel plans. Closed panel plans "only contract with a limited number of existing group practices,"[13] while open panel plans will contract on a need basis with any physician who meets the credentialing criteria.[14] In most managed care programs, the panel is closed. Although there are some programs that are available to any practitioner in the community, most contract with one or more selected medical groups or independent practice associations. The physician who is not connected with one of these selected entities has no opportunity to be on the panel of the managed care program. In the managed care setting, the arrangements with providers can range from Kaiser models, which use only one group of physicians, to network models, which use many groups and some individual practitioners.

The closed panel approach in managed care has many roots. Several programs were founded by providers to expand their business. An open panel approach would defeat the very purpose for which this type of program was founded. In addition, many managed care programs find it difficult to administer capitation payments,[15] risk pools, and other elements of physician payment when dealing with individual physicians in the community. These hallmarks of managed care are easier to manage if the plan contracts with groups or other provider entities. Many managed care programs have also found marketing easier when identifiable provider entities in the community can be cited as participants in the program; such a designation gives a "product differentiation" from fee-for-service indemnity, where any provider in the community may be utilized. Thus, most managed care programs exclude a majority of providers in the community for "business reasons."

The closed panel nature of managed care has not generated much activity in the courts. Since no one managed care program dominates the health care delivery system in any one community, it is difficult to bring a legal action based on anti-trust grounds. In *Capital Imaging Associates, P.C. v. Mohawk Valley Medical Associates, Inc.*,[16] a radiology group brought a suit to be included on the closed panel of an HMO. The defendants moved to dismiss the complaint contending that plaintiffs failed to allege an unreasonable restraint on trade and any anti-competitive effect.[17] The court

13. KONGSTEVEDT, *supra* note 1, at 16.
14. *Id.*
15. Explained in section VII. B.
16. 725 F. Supp. 669 (N.D.N.Y. 1989).
17. *Id.* at 676.

denied defendants' motion to dismiss, noting that plaintiff alleged the possible impact of lack of competition on the users of radiological facilities and services.[18] The court allowed discovery to proceed. On May 7, 1992, the court granted defendants' motion for summary judgement because the plaintiff was unable to show that the defendant's actions were restraint of trade. The case is now pending before the Court of Appeals.

In *Northwest Medical Laboratories, Inc. v. Blue Cross and Blue Shield of Oregon, Inc.*,[19] a medical laboratory challenged its exclusion from the closed panel of an HMO. The court went beyond merely stating that the HMO in question was not anticompetitive by noting that "there was evidence of the procompetitive impact of the defendants' conduct. . . . [O]ne of the central concepts behind the formation of Network was the use of a limited panel of providers in order to control utilization while ensuring that quality remained high."[20]

The courts have not been sympathetic to physicians and other providers who oppose closed panel programs. Physicians in the community who feel strongly about being excluded from a managed care program usually develop their own competing program rather than taking the issue to court. However, as managed care programs capture increasing market shares, more providers may seek judicial relief to join prepaid panels.

To date, providers who are excluded from managed care plans have been inclined to turn to the legislature for assistance. A number of states are considering "any willing provider" legislation, which in essence makes managed care programs "open panel" for one or more categories of providers. In addition, several major government payers are requiring "open panels" for their employee benefit plans. The Federal Office of Personnel Management, for example, requires open panel access to clinical psychologists and certain other professionals. This pressure to establish open panels both through the legislative arena and in government payment programs is expected to increase.

A managed care or provider entity plan that goes beyond good business or medical practices in credentialing staff to actively discriminate against individuals or certain classes of providers may face legal liability. Of course, the exclusion of any providers based

18. *Id.* at 677.
19. 794 P.2d 428 (Or. 1990).
20. *Id.* at 437.

on race, creed, color, or nationality would justifiably cause severe consequences.

Prohibited discrimination was at issue in the case of *Hahn v. Oregon Physicians' Service*,[21] where the court allowed the podiatrists who were excluded from a physician-sponsored, pre-paid healthcare plan to go to trial on the issues of an illegal group boycott and horizontal price-fixing agreement among the competitors.[22]

A look at restrictions on activities of existing members of a panel may indicate whether less discrimination could create liability for managed care plans. A Federal Trade Commission ("FTC") consent order[23] involving the Medical Service Bureau of Spokane, Washington explores this area. The FTC charged that the Medical Service Bureau played a major role in the payment of healthcare services in eastern Washington, and required all participating physicians to sign essentially an exclusive agreement. No provider in the service area of the Bureau could successfully practice medicine without being a member, and the exclusivity meant that no competitor could enter the service area and arrange for provider services since all specialists were exclusive to the Bureau. In a consent order with the FTC, the Bureau agreed to drop its exclusivity contractual provision. This indicates that the actions of a health program that controls a market will be scrutinized in a much different light than the actions of a minor component of the healthcare delivery system.

Exclusivity requirements imposed by managed care plans are not per se illegal. *U.S. Healthcare v. Healthsource*[24] involved a ruling by a United States District Court judge in New Hampshire that exclusive contracts with primary care physicians did not violate the antitrust laws because there was vigorous competition in the market. It appears that a legal problem would arise if the organization so controlled a market that there was no competition.

There is unquestionably an area of potential vulnerability with managed care credentialing that is used to inhibit competition. If a managed care plan dominated a community and used that domination to exclude certain physicians to force them to leave the community, liability could be imposed. Credentialing used to control a market may present a serious problem.

21. 868 F.2d 1022 (9th Cir. 1988).
22. *Id.* at 1030, 1032.
23. In re Medical Serv. Corp. Spokane County, 88 F.T.C. 906 (1976).
24. No. 91113-D (D.N.H. 1992).

VII. Provider Entity Credentialing

A. Overview

Most managed care programs do not contract directly with individual physicians, but contract with entities that either employ or contract with physicians, such as medical group practices and independent practice associations. These entities often have the responsibility to assure services are available, accessible, and acceptable, as discussed above. The ability of these organizations to meet their contractual obligations to deliver services to managed care enrollees is often based on the financial solvency of the provider. A financially solvent provider usually can deliver health services as required by its contract with the managed care program, while a financially weak provider will often encounter problems in delivering health services to enrollees. Thus, a very important component of credentialing provider entities is to determine whether the entity is financially able to survive in the prepaid health environment.

B. The Prepaid Healthcare Environment for Provider Entities

Twenty years ago, the medical care system was almost entirely fee-for-service. Most consumers paid health insurance premiums to an indemnity insurance carrier, which in turn paid healthcare providers on a fee-for-service basis. Provider payment methodology has significantly changed in the last twenty years. In addition to fundamental changes in most government programs, managed care has sought to pay providers on an advanced, fixed-fee-per-member basis instead of a fee for each service provided. This shift in payment methodology is beneficial. With the fee-for-service system, there is a financial incentive to overutilize services. The physician, because of his or her superior medical knowledge, has almost complete authority to order the consumer's health services. If that physician is compensated on the basis of the number and level of services ordered, there is an inherent incentive to be cost ineffective. Prepayment of providers gives incentives to be cost effective. However, prepayment does create certain potential problems.

In most managed health care programs, the provider entity is given a set fee per member per month. This fee, called capitation, is designed to cover not only the services to be rendered by the provider entity's own physicians, but also certain referral services to be rendered by specialists. If the provider entity is unable to

control its own costs or its referral costs, the capitation from the managed healthcare plan may not be sufficient for the provider entity to meet its healthcare obligations to members. If this occurs, the situation must be corrected or the provider entity may cease its operations. If the provider entity ceases operations, three consequences may occur: (1) A disruption or denial of medical care to the programs' members will occur since the provider entity is no longer in operation. (2) Unpaid referral providers may take legal action against either the managed care plan or the members who have received services, or both. The managed care program may have to pay the referral providers for services that it already paid through its capitation. If these obligations are too large, the managed care program could become insolvent. (3) The managed care program could suffer adverse publicity caused by the closure of one of its providers and be plagued by billing and other problems stemming from that closure. The harsh results of the closure of a provider entity mandates that managed care programs develop a process to prevent such problems from occurring.

C. Problem Prevention

Assuring the financial viability of contracted provider entities begins before the contract is signed. Every managed care organization should have a procedure for a pre-contractual audit. The audit should focus on four issues:

1. Does the provider entity have the financial resources to handle risks? The provider entity must have financial resources to absorb losses if utilization is higher than expected or other short term problems arise. A provider entity relying on capitation with no resources of its own is gambling. In addition to financial resources, a financial plan is necessary. A provider entity that has accepted a capitation without carefully budgeting its own costs and those for referral providers is speculating, which can prove disastrous.
2. Does the provider have the medical resources to deliver the services? The provider entity is contracting first and foremost to deliver medical services. It must have contracts with a sufficient range of providers to have a full range of services available. In addition, an entity that accepts capitation but pays for services on a fee-for-service basis is not changing the incentives to the providers and is gambling on appropriate utilization. Organiza-

tions that are pre-paid for medical services use various payment formulas to reimburse their providers.

3. Does the provider have the organizational and technological capabilities, such as computers, to administer a risk program? If a provider entity has the responsibility to pay referral providers and other expenses for which a bill is rendered after the services are delivered, there must be a claims processing system in place that allows for the evaluation and payment of these bills. In addition, since costs are incurred before the bill is received, a true financial picture can only be obtained by the use of a system that tracks actual costs and not just reported claims.
4. Does the provider have utilization controls to properly regulate inappropriate utilization of services? Managed care works only when health care is managed through controls on utilization, referrals, and other facets of the practice of medicine. An organization that does not have contractual agreements with providers for such controls and does not have a mechanism to enforce such controls has an uncertain financial future if it is being paid on a capitation basis but must pay providers on a fee-for-service basis.

D. Structuring the Risks

The precontractual audit can reveal important information about the provider entity. The decision to contract with a specific entity does not have to be "all or none." In other words, an organization need not choose between contracting with a provider entity and transferring full outpatient risks or not contracting with the entity at all. A managed care program can contract with a provider entity but can limit the risk transferred. Risk can be structured based on the ability of a provider entity to absorb it. The generally accepted approaches to limiting risks are: (1) limiting the services for which a capitation is paid to those that an entity provides directly through its contracted, capitated providers; (2) obtaining re-insurance from either the managed care program, third party insurer, or other entity that limits the risks transferred for certain catastrophic cases; (3) using "hold backs" in an account jointly owned by the managed care program and the provider entity in which certain monies are placed to cover referral and other costs if utilization is higher than expected; and (4) executing hold

harmless agreements with referral and other providers, agreeing that neither the managed care program nor the member shall be responsible for payment if the provider entity is unable to pay the fees.

E. Ongoing Monitoring Process

The financial status of an organization obviously changes over time, so the managed care program's precontractual audit of the provider entity should be viewed only as the starting point. The managed care program must continue to monitor the financial status of each provider entity, must be sure that its contract with the provider entity requires the provider to periodically report financial information as well as provide additional financial information upon request, and must review financial statements, such as profit and loss statements, accounts payable, long term debt, cash flow analysis, and claims accrual. The managed care program must know the provider is financially stable. An ideal time to review the financial status of entities is at the time of contract renewal.

The scrutiny of the financial information does not have to be uniform. A new organization must be scrutinized more closely than one that is well established and well known in the community. In addition, there are certain "red flags" that signal problems: member complaints, billings directly from referral providers, denial of care by referral providers, a seemingly large turnover of provider staff or primary care and referral providers, complaints from referral providers concerning unpaid bills or lack of communication from the provider entity, requests for cash advances from the entity, reluctance to share financial information, the closing of clinics and offices, and the termination of provider contracts by other managed care programs. If the particular provider entity is the only provider of services from the managed care network in a particular area, the managed care program should be especially sensitive to potential financial problems given its high degree of dependency on the entity.

Through these periodic reviews, problems can be detected early, allowing the program and provider to resolve the problem in a cooperative fashion. Problems, concerns, and solutions can be raised through informal discussions and meetings. A restructuring of the risk arrangement, introduction of a holdback or stop-loss program, or renegotiation of the capitation may be necessary to reflect the reality of costs and utilization. A constructive dialogue must be

initiated to resolve these problems. If more formal action is necessary, the dispute resolution provisions of the contract with the provider must be consulted.[25]

VIII. The Future of Credentialing in Managed Care

There is a strong trend towards increased credentialing in managed care. Credentialing is a fact of life, and the credentialing of independent providers and provider entities will continue whether by managed care, coordinated care, or health maintenance entities.

With a movement toward managed competition as a vehicle to address United States health problems, more focus will be placed on managed care plans generally. For plans to be competitive, they must be able to generate cost effective, high quality medical care. Central to that goal is a need to attract and retain efficient practitioners. It is essential to have the "right" group of physicians associated with a given program, which requires effective credentialing efforts. The area of credentialing is likely to grow in importance and could conceivably be subjected to increased legal scrutiny.

25. If the pre-contractual audit and ongoing monitoring process are ineffective, the managed care program must take action to assure its members are receiving needed health services and to limit its own financial exposure. If a provider entity becomes insolvent and ceases operation, the members of the managed care program must be shifted to an alternative delivery system, or it must coordinate with the employers to move members into alternative health care programs. In addition, the termination language of the managed care contract should dictate the payment of the provider's financial obligations. In certain situations, the plan should consider action against the provider entity and certain individuals involved with it. For example, if the organization received capitation money but did not pay referral providers, there may be a legal basis to recover the organization's assets. If individuals in the organization have taken monies for which they were not entitled, direct action against these individuals should be considered. If the organization has filed bankruptcy, proofs of claim and other documents may need to be filed. Referring entities with unpaid bills may seek recovery from either the managed care program or the members, or both; the contracts with referral providers will dictate whether the provider is solely responsible for payment. Other factors such as the use of referral forms that inform referral providers that payment will only be available from the provider entity or the custom and usage of the referral providers to look only to the provider network for payment may mitigate the managed care program's potential liability for provider payments.