Economic Credentialing – Dead or Alive in an Era of Healthcare Reform and Competition?

Co-Sponsored by *the Hospitals and Health Systems; In-House Counsel; Medical Staff, Credentialing and Peer Review; Physician Organizations; and Regulation, Accreditation, and Payment Practice Groups*

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Environmental Overview

- Identification of “Never Events”, i.e., unacceptable medical errors, resulting in reduced or denial of payments by CMS and private payors.
  - Surgery performed on wrong body part
  - Surgery performed on wrong patient
  - Unintended retention of foreign object in patient after surgery

Environmental Overview (cont'd)

- Emphasis on Pay for Performance ("P4P") by private and public payors regarding expected compliance with certain protocols, healthcare practices and quality outcomes.
  - Asthma
  - Diabetes
  - AMIs

Environmental Overview (cont'd)

- Federal ACE Demonstration Project
- Federal healthcare reform?
  - Reduction of costs
  - Promotion of quality

Environmental Overview (cont'd)

- Transparency to the general public via hospital rankings, published costs and outcomes, accreditation status and mandatory reports to state and federal government.
- Greater demands being placed on Boards of Directors and hospital management to develop sufficient resources to ensure that quality of care standards and expectations are met through the hospital's quality improvement program that adopts metrics and benchmarks to measure progress in meeting targeted clinical quality standards as part of the hospital's corporate and governance policies.

Environmental Overview (cont'd)

- Good quality means good business.
- Adoption and enforcement by Joint Commission of focused and ongoing performance monitoring ("OPPE" and "FPPE").
- More aggressive enforcement environment, especially by the OIG, which is beginning to hold hospital boards and management responsible for the provision of substandard or unnecessary care which lead to "Never Events" or adverse patient outcomes.

Environmental Overview (cont'd)

- Legal and accreditation expectations and requirements require that medical staff physicians are appropriately credentialed and privileged to exercise each and every one of the clinical privileges given to them at time of appointment and reappointment.
- Failure to abide by identified quality standards expectations will give rise to more malpractice and corporate negligence liability claims.

Environmental Overview (cont'd)

- At the same time, because physicians are finding their professional incomes being reduced and want to be less reliant on the hospital, they are entering into competing service lines such as:
  - Surgicenters
  - Urgent care centers
  - Specialty hospitals
  - Imaging and other diagnostic services

Environmental Overview (cont'd)

- Employment/independent contractor arrangements with competing hospitals
- Increased employment by physicians of CRNAs, scrub nurses, APNs, nurse midwives and other independent and dependent practitioners in lieu of using hospital personnel

- These competing physicians and activities have arguably led to reduced hospital revenue and a lower bottom line making it difficult for hospitals to purchase equipment, EMR systems, recruit physicians, renovate and expand hospital space, maintain existing patient care services or to expand service lines.

Environmental Overview (cont'd)

- All of these developments are forcing hospitals to re-evaluate their relationships with new and existing medical staff physicians, particularly those who are direct competitors of the hospital.

Murphy v. Baptist Hospital

- Background of Dispute
  - In response to the opening of a competing heart hospital, Board of Directors adopted an Economic Credentialing Policy ("Policy").
  - "Any physician who, directly or indirectly, acquires or holds an ownership or financial interest in a hospital anywhere in Arkansas is ineligible for initial or renewed professional staff appointments or clinical privileges at any Baptist hospital."
  - Policy applied to owners, investors, and immediate family members – very broad definition.
  - No hearing rights were provided if a current physician loses privileges.
  - In order to obtain or maintain privileges, physician or family member had to completely divest themselves of this ownership/financial interest.

Murphy v. Baptist Hospital (cont'd)

- Several physician affected by this Policy sued to enjoin implementation under a number of theories.
  - Tortiously interferes with patient-physician relationship.
  - Is contrary to public policy.
  - Is an unconscionable business and trade practice in violation of Arkansas Deceptive Trade Practices Act.
- Trial court agreed and enjoined enforcement of the Policy in 2004.
- Decision was upheld by the Arkansas Supreme Court and was remanded for trial which took place between March 10-20, 2008.

Murphy v. Baptist Hospital (cont'd)

- On February 27, 2009, trial court entered an Order for Permanent Injunction and made the following findings and rulings:
  - Patient-physician relationship carries with it a reasonable business and patient expectations.
  - A contract with the patient exists.
  - Referrals are the lifeblood of a physician's practice.
  - Hospital acknowledged that Policy would disrupt a patient's relationship with their physician of choice.

Murphy v. Baptist Hospital (cont'd)

- Court determined that Baptist Health potentially interfered with patient-physician relationship because:
  - The Hospital specifically identified the plaintiff physicians who would be affected;
  - The Policy would make it difficult for any physician associated with competing heart hospital to admit patients to Baptist Health;
  - Because the Hospital was an exclusive, in-network provider with one or more managed care plans, it knew and warned the plaintiffs that retention of their financial interest in any specialty hospital would result in their exclusion from the insurance networks;

Murphy v. Baptist Hospital (cont'd)

- Hospital confirmed with Blue Cross/Blue Shield that plaintiffs would be excluded if they no longer had staff privileges at Baptist;
- Although plaintiffs never lost privileges at the Hospital, the court determined that imposition of the Policy would in fact cause compensatory damages, would interfere with patient relationships and would result in loss of referrals;
- Policy was contrary to public policy because:
  - Arkansas protects the patient's right to the physician of their choice as reflected in a number of court decisions. The Policy interferes with this relationship.

Murphy v. Baptist Hospital (cont'd)

- Restrictive covenants in employment agreements are not generally enforceable in Arkansas.
- The Patient Protection Act of 2005 was passed so as to allow patients to be given the opportunity to see the health care provider of their choice and the opportunity of providers to participate in health benefit plans.
- The Medicare Act guarantees patients basic freedom of choice.
- The AMA Code of Ethics provides that "free choice of physicians is the right of every individual."

Murphy v. Baptist Hospital (cont'd)

- Public policy favors the establishment and acquisitions of specialty hospitals and disfavors economic credentialing.
- The court cited to expert testimony and federal studies which concluded that economic credentialing does not benefit the community.
- Economic credentialing punishes physician investment in specialty hospitals and punishes physicians for engaging in conduct that is "illegal, negatively affects patient care, impedes advancements in medical technology and the construction of a modern health care delivery system and interferes with patient-physician relationships. The court also cited to an AMA policy.

Murphy v. Baptist Hospital (cont'd)

- The Hospital acted contrary to its obligations as a 501(c)(3) not-for-profit, tax-exempt charitable organization because as one of the listed factors of requiring that a hospital operate for the benefit of the community and to demonstrate that it qualifies for exempt status that the Hospital is willing to hire any qualified physician.

Scenario 1

- Metropolis is a three hospital town which only needs two facilities.
- Although one has a hospitalist program, all are served by multiple, independent small and medium multi-specialty physician practices.
- Major tertiary care is transferred to University Hospital 20 miles north.

Scenario 1 (cont'd)

- To offset flattening revenue sources and declining professional income, physicians are entering into competing services that are currently provided by the local hospitals in lieu of joint venture arrangements with these facilities.
  - ASCs
  - PT, OT
  - Radiology and imaging
  - Urgent care centers

Scenario 1 (cont'd)

- As a result of these competing physician services, client hospital has suffered a sharp negative financial downturn and now wants to take steps to encourage institutional loyalty and improved physician relations.
- A Strategy Committee has been formed comprised of three lay Board members and three MEC members. They have contacted you to evaluate the legal, political and practical implications of the following policies or actions:

1. Questionnaire

- An extensive questionnaire on a revised medical staff application form and re-appointment application form, inquiring as to financial or other connections of applicants in clinic endeavors, as well as activities in the other two community hospitals.

1. Questionnaire (Considerations)

- Degree of detail: personal, family, partners, etc.
- Compilation and review of information: who performs, who has access.
- Actions based upon data.
- Who controls the application forms – hospital or medical staff?
- Are forms going to be used to screen out competitors? Is this legal?
- What if physician refuses to provide information?
- Relevance?

2. Limitation on Leadership

- Prohibiting any new applicant or existing staff member seeking reappointment to serve as a chair of any medical staff committee, member of the MEC, the Governing Board, or as an officer or department chair of the medical staff, if he or she has a financial interest in a competitive organizational endeavor.

2. Limitation on Leadership (Considerations)

- Connection between leadership role and financial relationships.
- Access to strategic plans and business developments.
- Shrinking pool of leadership.
- How can this restriction be implemented?
- Does this have to be in the medical staff bylaws or can the Board implement through a corporate policy?
- Protections through corporate duties and confidentiality?

3. Limitations on Active Staff Status

- Limiting Active Staff Category membership, i.e, voting and leadership roles, to those physicians who attest to and can document if required that at least 50% of their clinical practice occurs at our institution.

3. Limitations on Active Staff Status (Considerations)

- Balance of prerogatives vs. duties
- Difficulty in documenting 50% standard for some physicians
- What constitutes “clinical practice”?
- Is this a violation of Anti-Kickback?
- Does this raise antitrust issues?
- What will Medical Staff not place in Bylaws?

4. MOB Usage Limitations

- Restrict eligibility to rent the hospital's MOB space to those physicians who are members of the hospital's Active staff.

4. MOB Usage Limitations (Considerations)

- Probable limited impact.
- Negative affect on professional relationships.
- Adverse to hospital's needs?
- Hospital does not need Medical Staff approval to implement.
- How is Active Staff being defined?

5. Restricted Staff Eligibility

- Limit membership on the medical staff to those physicians who are not on the Active Medical Staffs of the other two hospitals, except in extraordinary instances deemed essential to specific patient care requirements as determined by the Governing Board.

5. Restricted Staff Eligibility (Considerations)

- Controlled by dynamics and needs of medical community.
- Employed vs. independent practice challenges.
- Perhaps beneficial; perhaps detrimental.
- Does the hospital have more flexibility on the front end for new applicants then for existing staff members?

6. Limitations on Appointment of Other Hospital's Leaders

- Decline to appoint, or reappoint, any physician who serves as a committee chair, department chief or elected officer of the medical staff of either of the other two hospitals.

6. Limitations on Appointment of Other Hospital's Leaders (Considerations)

- A type of 'loyalty' criteria.
- Assumes a significant pool of practitioners.
- Benefit vs. burden to the hospital.
- On what authority can this limitation be adopted and implemented?

7. Limitation on Diagnostic Information

- Permit usage of diagnostic imaging and laboratory test information conducted by other hospitals, but not permit such information for hospital records if performed by labs or imaging centers in which the attending physician has a financial interest.

7. Limitation on Diagnostic Information (Considerations)

- Benefit to hospital, but not patient.
- Rationale: quality assurance vs. financial benefit?
- Impact on costs and patient rights.

8. ED Call Coverage

- For desired ED call coverage specialty services, limit roster eligibility to those specialists who exclusively practice at our facility. For undesired specialty services, exempt coverage responsibility for those specialists who exclusively practice at our facility.

8. ED Call Coverage (Considerations)

- Realistically, is there “desirable” call coverage.
- Exemptions for exclusive users, practice desirable, but questionable quality impact.
- Is ED call a privilege or a duty?
- Can other similar restrictions be imposed, i.e., removal from physician referral services; cannot be part of any new programs or joint ventures; no recruitment support?
- Are these legally defensible?
- Employment strategy alternatives?

9. Call-a-Nurse Referral Program

- In the Call-a-Nurse Referral program of the hospital, restrict physician eligibility to those Active Staff members who exclusively practice at our facility.

9. Call-a-Nurse Referral Program (cont'd)

- Driven entirely by success and desirability of program.
- Some practitioners: "No thank you."
- Difficult to justify for some sub-subspecialists, e.g., plastic, psychiatrists, etc.

Scenario 2

- 100 bed hospital is located in a rural town but in a prime vacation area proximate to a city.
- Hospital can easily recruit physicians but has difficulty maintaining patients who typically go to the city for more complicated care.
- Hospital has a high Medicaid and indigent care population due to lower paying positions in the tourist industry, a migrant farm population, and a local chicken-packing plant.

Scenario 2 (cont'd)

- It has a cardiac program and obtained a CON for cardiac caths 5 years ago but outcomes have been poor leading to patient out migration to the city for these services and leaving a heavily Medicare/Medicaid/indigent patient population.
- To improve services, Hospital builds a Cardiac Center of Excellence and recruits and employs a highly renowned cardiac surgeon from the city to manage the Center.
- It also hires three of the remaining four cardiac surgeons on staff but one of them, Dr. Callahan, remains independent.

Scenario 2 (cont'd)

- Part of the Center's strategic and management plan is to develop a profiling plan based on industry standards and software that will allow the hospital to compare:
  - Physician performance to payer protocols and outcome expectations
  - Lengths of stay
  - Morbidity and mortality data
  - Cost per patient visit
- Reports are prepared and distributed quarterly to each cardiac surgeon and reviewed with each by a Hospital Administrator and/or the Director.

Scenario 2 (cont'd)

- The Director and one of the employed surgeons are within acceptable standards but two of the other employed physicians, Drs. Purtell and Welch, and Dr. Callahan are not.
- After several attempts of meeting, educating and working with all three surgeons, Dr. Purtell improves, but Welch and Callahan do not. They dismiss the reports as being garbage and maintain that their patients are sicker.
- Hospital has asked its legal counsel for advice regarding the following possible actions concerning Welch and Callahan:

1. Medical Staff or Contractual Corrective Action?

- Should it initiate Medical Staff action against Drs. Callahan and Welch? What approach does it take? Does it chose to proceed within the Medical Staff process or as an administrative matter? If there's an contractual (including employment) relationship, does that contractual relationship make a difference? If the Hospital proceeds as a Medical Staff matter, what form does it take – proctoring? Monitoring? Suspension? And, if so, should the Hospital and/or the Medical Staff take any steps before initiating action?

1. Medical Staff or Contractual Corrective Action? (Considerations)

- First, how do we classify issues – clinical or administrative? Inside Medical Staff process or outside, even if clinical in nature?
- Need to avail of state law peer review protections?
- Degree of Medical Staff support on clinical issues?
- What level of quality deficiencies have occurred?
- Supportive action as first step.
- Capacity of Medical Staff Leadership can be decisive.
- Is there employment agreement leverage to consider?

2. Employed Practitioner Actions

- What, if any, additional steps should Hospital take against Dr. Welch as a result of her employment by the Hospital? Should such action be in addition to or in lieu of Medical Staff action?

2. Employed Practitioner Actions (Considerations)

- Again, are the deficiencies truly clinical and does the Medical Staff need to protect itself on grounds of negligent credentialing?
- Scorched earth tactics versus minimum necessary.
- Alternatively, is termination sufficient to dispose of the problem?
- What does the contract say?
  - With or without cause termination?
  - Does contract have clean sweep provision?

3. Bundled Payment Demonstration Situation

- Does, and if so how, the recommended course of action change if the Hospital is participating in the Demonstration Project for bundled payment?

3. Bundled Payment Demonstration Situation (Considerations)

- Physician's formula for share of payment may have a connection to quality (both employed physician and Medical Staff member).
- Crystallizes hospital concerns of costs vs. quality.
- Clearly a contract issue for at least the employed practitioners.
- Does it increase justification for action against outlier physician?

4. Third Party-Payor Contract Requirement Standards

- What course of action should the Hospital take if a major dominant payor is demanding that all Medical Staff members have a contract with the payor but Drs. Callahan and Welch would not meet the payor credentialing requirements because of their data? What if the payor requests the data from the Hospital? Is the data peer review? Does the MD have ability to access his peers? Can and should the hospital initiate Medical Staff action as a consequence of the payor issues? How is its approach different with its employed physicians?

4. Third Party-Payor Contract Requirement Standards (Considerations)

- Completely hypothetical – NOT!
- Increased justification for Medical Staff action?
- For medical staffs dominated by independent practitioners, implementation challenging.
- Characterization and protections for the data may be important for this and other reasons.
- Access to comparative data by all staff members a different, and challenging issue.
- Same considerations for Medical Staff action.

5. Excess Cardiac Surgery Capacity?

- After the hospital finally gets everyone on track and the Center of Excellence running smoothly, it realizes that the increased efficiencies justify four cardiac surgeons on staff rather than five. What course of action do you recommend? How does it impact existing Medical Staff members? Future members?

5. Excess Cardiac Surgery Capacity? (Considerations)

- In theory, if other than employed physicians, a market driven issue.
- Quandary: lowest cost to hospital physician with worst quality vs. highest cost with best quality.
- Termination of employed physician vs. independent physician.