Katten

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Integrating Medical Staffs in a Multi-Hospital System: Challenges, Options and Proposed Solutions

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Environmental Overview

- Factors leading to mergers, acquisitions and affiliations
  - — Increased competition
  - — Access to capital
  - — Declining reimbursement
  - — Higher labor costs and operating expenses
  - — Movement from volume to value as a basis of reimbursement
  - — Efforts to improve efficiencies, quality of services and reduce costs
  - — Greater market leverage
- Benefits to medical staff integration
  - — Uniform and standardized medical staff bylaws, rules, regulations and policies
  - — Single appointment and reappointment process
  - — Standardized peer review and fair hearing procedures
  - — Uniform credentialing and privileging criteria

Environmental Overview

- Common Medical Staff leadership structure
- Uniform policy on restricting access to competing physicians
- Improving quality and continuity of health care services through adoption and standardized quality metrics and outcome standards
- More uniform physician compensation and contract standards
- Greater ability to share physician peer review and quality outcome data by and between affiliated hospitals and facilities
- More effective “on boarding” for managed care contracting
- Better able to maximize state and federal peer review privileged protections

Challenges, Options and Proposed Solutions

- **Single Unified Medical Staff**
  - — Applicable Legal Standards
    - Medicare Conditions of Participation – 42 CFR Sections 482.12, 482.22
    - Accreditation standards – MS.01.01.01, EP 37
    - State and local laws
  - — Pros
    - Uniform appointment, reappointment and hearing process across the system for all physicians
    - Uniform policies and procedures
    - Can be implemented by region/division
    - Amendment process for bylaws, rules, regulations and policies is more streamlined
    - Must follow Medicare CoPs and state laws regarding which professionals can serve on the Medical Staff

Challenges, Options and Proposed Solutions

— Cons

- Disparate cultures, Medical Staff profiles (employed versus independent), geography, etc., make the effort to unify more difficult to accomplish
- How do you choose the best model set of bylaws and policies?
- Amendment process to achieve single unified staff is detailed and success of obtaining approval is uncertain
- Must take into account different state statutory requirements if part of a multi-state system – will state approve a single staff?
- Must follow Medicare CoPs and state laws regarding which professionals can serve on the Medical Staff
- Can only have a common parent board and not separate hospital boards.
- Potential for unraveling – must give Medical Staffs the ability to opt-out.

Challenges, Options and Proposed Solutions

— Alternatives

- Adopt common or uniform forms and provisions such as the pre-application, appointment, reappointment and hearing procedures but maintain committee and Medical Staff leadership structure
- Create a CVO
- Create centralized credentials committee for the system or by region
- Adopt a uniform pre-screening application
- Adopt same bylaws, with appropriate variations, but with different cover sheets
- Adopt a uniform access policy to prevent competing physicians from obtaining and maintaining membership and clinical privileges

- Significantly Different Medical Staff Bylaws, Rules and Regulations

— Applicable Legal Standards

- State Hospital Licensing Act

Challenges, Options and Proposed Solutions

- Accreditation Standards
- Medicare Conditions of Participation

— Pros

- Differences reflect disparate cultures, geography and historical nuances – helps to keep the peace
- For multi-state systems, bylaws reflect different state standards for compliance, peer review, licensure and Medical Staff eligibility standards
- Hospitals could be under different accreditation standards although all must comply with CoPs
- Bylaws and regulations are likely to be less uniform if system is composed of academic medical centers, suburban, rural and critical access hospitals – one size does not fill all

Challenges, Options and Proposed Solutions

— Cons

- Can serve as an impediment to future consolidation, collaboration and efficiencies
- Conflicting FPPE, OPPE, peer review and related standards and eligibility criteria and requirements undermine efforts to upgrade and maintain quality of the Medical Staff and can increase negligent credentialing and malpractice liability exposure
- Some bylaws could be out of compliance with Medicare CoPs, as well as accreditation and statutory requirements
- Efforts to adopt uniform provisions can be difficult at best and time consuming
- How is an “investigation” defined in the Bylaws for Data Bank reporting purposes versus routine peer review?
- Different standards for what does and does not trigger a hearing
- Different staff categories with potential loss of certain membership rights

Challenges, Options and Proposed Solutions

— Alternatives

- Conduct a compliance audit in order to determine whether there are regulatory compliance gaps
- If seeking to adopt some uniform provisions do a comparison check to see how similar or different are the existing bylaws and regulations
- Pre-screening policies may be more easily adopted depending on whether the hospital or the Medical Staff controls the process
- Seek common ground on less controversial provisions such as the appointment/reappointment and fair hearing procedures
- Try to sync up appointment/reappointment procedures and schedules
- Create system/region/Bylaw Committee with appropriate Medical Staff representation
- Streamline Bylaws and move sections to manuals or plans, i.e., Credentialing Manual, Fair Hearing Plan, in order to implement a more expedited amendment process

Challenges, Options and Proposed Solutions

- Conflicting Credentialing/Privileging/Eligibility Criteria
  - — Applicable Legal Standards
    - Hospital Licensing Acts
    - Standard of care issues
    - Accreditation standards
    - Medicare Conditions of Participation
  - — Pros
    - Allows for diversity of members and categories
    - Maintaining differences avoids the need to terminate clinical privileges or provide hearing rights if the physician would no longer be eligible and therefore would lose privileges
    - Privileges do need to be site specific and depends on the nature of clinical services offered by the hospital

Challenges, Options and Proposed Solutions

— Cons

- Can result in alleged breaches of standard of care depending on the degree of differences as reflected in department criteria and policies such as use or non-use of core privileges and different eligibility standards
- Could be granting privileges to competitors at one facility who would be prohibited from obtaining membership at an affiliated hospital depending on pre-screening standards
- Relying on utilization/quality standards to demonstrate current competency at some but not all facilities
- Lack of uniform adoption of required quality metric/outcome standards imposed by ACOs, private payers, etc. – has a direct impact on a hospital's reimbursement
- Are FPPE/OPPE standards different? Do they even exist?
- Conflicting Code of Conduct/Disruptive Behavior Physician Wellness Policies
- Required versus permissive use of hospitalists

Challenges, Options and Proposed Solutions

— Alternatives

- You need to conduct a comprehensive analysis to determine the degree of differences in criteria and potential resulting liability exposure and adverse impact on reimbursement
- You need to evolve towards common eligibility standards
- You need to examine impact on a physician's existing privileges - who wins and who loses and if hearing rights are triggered
- Is there a legitimate basis to grandfather physicians?
- Allow 12-24 months to meet criteria. If not met then privileges are voluntarily relinquished with no Data Bank reporting obligations
- During interim period closely monitor outcomes where standards are "lower" or not as demanding
- Reduce or eliminate "volume" standards for eligibility and look to other loyalty factors, i.e., serving under-served patent populations, treating indigent care/Medicaid patients, service on committees
- Consider "membership only" category

Challenges, Options and Proposed Solutions

- Use multi-disciplinary group to evaluate and identify common standards
- Amend bylaws and policies accordingly

- **Conflicting Privilege and Immunity Statutes and Existing Policies**
  - — Applicable Legal Standards
    - State peer review and immunity statutes
    - Patient Safety and Quality Improvement Act of 2005
    - HCQIA
    - Applicable case law
  - — Pros
    - Assumption is that each hospital in a multi-state system has modified its bylaws and policies to maximize these privilege and immunity protections to apply in state and/or federal proceedings and investigations

Challenges, Options and Proposed Solutions

- Combined privileges maybe broader than a single privilege
- The more the merrier

— Cons

- Tracking changes in state peer review statutes and applicable case law for multi-state systems is not easily accomplished and could lead to different bylaws, policies, and practices. What information is privileged and what actions are eligible for immunity protections will differ
- Waiver issues also vary especially if sharing confidential information across state lines and even within the system depending on the categories of providers which can access the protections
- Also, in the context of CINs/ACOs the scope of activities and provider facilities that are covered are different and may not be available at all
- Conflicting peer review policies and procedures forms will impact the scope of privilege and immunity protections and liability exposure

Challenges, Options and Proposed Solutions

— Alternatives

- HCQIA immunity protections have been adopted by most states thereby giving the system a base level of immunity protections
- Both state and HCQIA immunity protections could apply depending on the facts and circumstances of the dispute in question and whether you are in compliance with the immunity requirements
- Keep in mind that attorney-client and insurer/insured privileges may be separately applicable
- Consider participating in a patient safety organization ("PSO") under the Patient Safety and Quality Improvement Act of 2005
  - — Scope of privileged activities under the Patient Safety Act are typically broader than activities under state privilege protections
  - — Patient Safety Act (PSA") privilege applies to all licensed facilities in the state
  - — Privileged information can be freely shared among affiliated providers throughout the system

Challenges, Options and Proposed Solutions

- Privilege protections apply in all state and federal proceedings whereas state peer review statute will only apply in state court and state causes of action, i.e., defamation and breach of contract, but not in federal court for federal actions such as in discrimination or antitrust claims
- PSA allows a non-provider corporate parent to be considered a provider and to be part of a single system patient safety evaluation system thereby enabling it to access the privilege protections
- Privilege can never be waived under any circumstance

— Economic Credentialing Issues - Background

- Hospitals are becoming more selective over which physicians can obtain and maintain membership and clinical privileges
- Systems are developing pre-screening applications which focus on questions of whether an interested physician is employed by a competing group, has a financial interest in a competing facility, or otherwise has significant conflicts of interest – these physicians do not get an application – decision is not reportable

Challenges, Options and Proposed Solutions

- These decisions need to be Board-driven – better to base policy on issues such as continuity of care, quality, costs and utilization as well as identified adverse economic impacts affecting the system by granting competitors Medical Staff membership
- Economic credentialing is legal

— Applicable Legal Standards

- Current medical staff bylaws and policies
- Hospital licensing statutes
- Antitrust, Anti-Kickback statutes

— Pros

- Protects hospital and Medical Staff from loss of referrals and revenue by preventing competing physicians from obtaining and maintaining membership and privileges
- Can require applicant to participate in ACO/CIN contracting

Challenges, Options and Proposed Solutions

- Can require higher eligibility for participating in an ACO/CIN
- Allows hospital to be more selective and better maintain quality and continuity of care
- Prevents disclosure of sensitive competitive and strategic information
- Avoids unnecessary patient transfers to competing hospitals and facilities
- A pre-screening application form is typically used

— <u>Cons</u>

- Could lead to legal challenges based on allegations of illegal anti-competitive conduct, discrimination, breach of contract, tortious interference, etc., especially if applied to existing members without some form of hearing
- Politically difficult to obtain Medical Staff support
- Requires well documented justification and must be Board driven

Challenges, Options and Proposed Solutions

- If the Medical Staff controls the pre-application, application and reappointment forms it may be difficult to include economic screening questions
- Amending bylaws to authorize adoption of these standards probably more difficult especially as applied to existing Medical Staff members

— <u>Alternatives</u>

- Should evaluate pre-screening, pre-application forms and applications to see what questions are being asked and then modify
- Best practice is to develop standard forms and conflict of interest policies across the system which can be used to prohibit competing physicians from serving on the Board or in Medical Staff leadership positions
- Conflict of interest policies should ask whether the physician not only has economic interests or a relationship with competing facilities, but also whether they serve in leadership positions and/or have contractual relationships with competing hospitals

Challenges, Options and Proposed Solutions

- Some systems actually have applied these restrictions to existing Medical Staff members such that they will not be reappointed if these competing economic interests continue to exist
- Ideally, an effort should be made to incorporate the Board policy and standards and these appointment and reappointment restrictions into the Medical Staff bylaws, although such an effort is likely to be difficult

- **Impact on Existing and Different Exclusive Contracts**

  — Applicable Legal Standards

  - Current exclusive contracts
  - Anti-Kickback and statutes
  - IRS employment standards

Challenges, Options and Proposed Solutions

— Pros

- Maintaining existing exclusive contracts that have been in effect for some period of time can help to maintain continuity of quality health services given the familiarity that the group has with the hospital and supporting personnel, use of equipment and other benefits derived from these arrangements
- Maintaining the groups could help to retain referral relationships between the hospital and its existing Medical Staff
- Some existing groups may already be staffing more than one system hospital – changing groups could be significantly disruptive

— Cons

- Different exclusive groups could have conflicting contract terms – is there a clean sweep provision whereby hearing rights are waived?
- Quality results and standards of care could vary
- Are all the groups required to participate in MCO arrangements?

Challenges, Options and Proposed Solutions

- Differences between groups that are employed versus under contract and impact on apparent agency liability claims
- Recruitment problems
- Are some groups protected and state/federal privilege statutes and others are not?
- Some groups may require a subsidy due to Medicaid indigent care populations whereas other do not

— Alternatives

- Group mergers by region
- RFPs between existing and/or outside groups
- Work toward standardized agreements/requirements

- **Impact on Existing and Different Physician Contracts**

— Applicable Legal Standards

- Existing contracts

Challenges, Options and Proposed Solutions

- IRS compensation standards
- Anti-Kickback and Statutes

— Example Physician Contracts

- Employment
- Medical Director
- Medical Staff leadership positions
- ED coverage
- Specialized service contracts
- Loan/support agreement
- Recruitment agreements

— <u>Pros</u>

- Leaving existing contracts in place will maintain continuity of services resulting in less disruption at least during transition period

Challenges, Options and Proposed Solutions

- Allows system to better evaluate performance of providers pending a decision on whether to maintain, terminate or consolidate services
- Helps to maintain existing referral and other relationships with the hospital and Medical Staff

— Cons

- Conflicting responsibilities and lack of standardized compensation arrangements
- Stuck with long term commitment and difficulties in achieving amendments
- Agreements may be violative of IRS, Anti-Kickback and Start standards
- Employed v. unemployed Medical Staff officers and leaders
- Breach of contract, tortious interference and other claims if agreements are terminated or not renewed
- Potential loss of loyal and referring physicians

Challenges, Options and Proposed Solutions

— Alternatives

- Need to inventory all contracts of incoming physicians to determine scope of conflicts and issues noted above
- Reasonable efforts to standardize contract terms at all levels should be the goal
- Need to consider a transition period for all unless inventory identifies serious legal and related liability issues
- Efforts to integrate and collaborate can be assessed during interim period

- **Impact on Existing Medical Staff Officer, Department and other Leadership Positions**

— Applicable Legal Standards

- Existing Bylaws, Rules and Regulations

Challenges, Options and Proposed Solutions

- Accreditation standards
- Hospital Licensing Acts

— Pros

- Maintaining current leadership structure during a transition period is critical to maintaining Medical Staff support and avoiding desertions due to perceived or actual loss or diminishment of independence
- Transaction plan may have already been developed and shared with Medical Staff leadership in advance of merger/affiliation

— Cons

- Conflicting or different responsibilities and eligibility standards
- Determining who has primary responsibility and if conditioned on system or system Medical Staff leadership or committee approval
- Has a limiting effect on efforts to integrate
- Used as a way to protect less qualified or non-qualified Medical Staff members

Challenges, Options and Proposed Solutions

— Alternatives

- Need a transition game plan which evaluates which leadership changes can be more easily accomplished
- If the system has moved to system-wide departments then consider appointing current Department/Section Chairs in the merged hospital as Vice Chairs

Firm Bio

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A nationally recognized advisor to health care providers across the country, Michael Callahan provides deeply informed business and legal counseling in all areas of hospital-physician relations and health care regulatory compliance and governmental investigations, including the Emergency Medical Treatment and Active Labor Act (EMTALA), the Health Insurance Portability and Accountability Act (HIPAA), Medicare Conditions of Participation (CoPs), hospital licensure and accreditation standards. He is widely respected for his leading work on the Patient Safety Act from a regulatory compliance, policy and litigation standpoint, including the development of patient safety organizations (PSOs).

The knowledge to identify efficient and practical solutions

Health systems, hospitals and physician groups large and small across the country come to Michael for practical, real-world guidance and answers to challenging legal and operational issues, which he can provide quickly because of his many years of experience. He understands the reality of hospital quality, peer review, risk management and related operational legal and regulatory complexities and can rely on a large client base in order to provide better and comparative solutions.

He also is sought out by many of the largest health systems around the country for his understanding and interpretation of the Patient Safety Act. In a case of first impression he advised a national pharmacy that became the first provider to successfully assert an evidentiary privilege under the Patient Safety Act. Since that case, he has represented or advised many hospitals, physician groups and other licensed providers in creating or contracting with federally certified PSOs and has been directly involved in most of the major state appellate and federal court decisions interpreting the Patient Safety Act.

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