

The ABCs of Antitrust in Health Care, Part IV: Medical Staff Privileges, Exclusive Physician Contracts, and Peer Review

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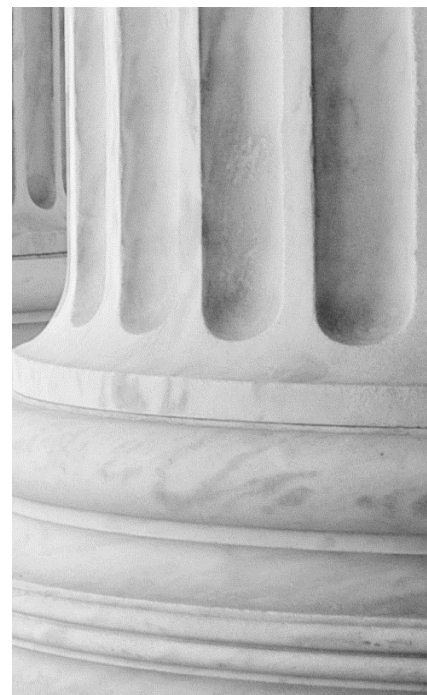
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Overview

- Structure of Hospital/Provider Relations
- Basic Antitrust Principles
- Important Defenses and Exemptions
- Credentialing and Peer Review
- Exclusive Contracting/Closure of Medical Staff
- Hospital-Provider Joint Ventures

Structure of Hospital/Provider Relations

- Relations can be complicated—not every physician “works” for a hospital; physicians may practice at several hospitals.
- Physicians apply for privileges at a hospital.
 - If granted privileges, physicians may provide services at the hospital.
 - Privileges define *scope* of services, not equivalent to licensure.
 - Last for a set period of time, e.g., three years, at which time physicians must reapply.
- “Credentialing” refers to the process of “obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services....”
Sometimes “credentialing” and “privileging” are distinguished.

- Once granted privileges, physicians become part of the hospital's medical staff (MS).
- Historically, most physicians were not hospital employees; but employment is increasing.
 - Employment relationships can impact who is on the medical staff and subject to medical staff bylaws—depends on the hospital.
- Relations among staff can be complicated:
 - Employed v. contracted;
 - Overlapping expertise;
 - Physician competitors;

- MS bylaws establish the rights, duties and responsibilities of the MS and each of its members and define the MS' relationship with the hospital's governing body and administration.
- Ideally, the medical staff, hospital board, and administration should work cooperatively and interdependently.
- Medical staff bylaws set up various committees to handle medical staff responsibilities, credentials, infection control, Q/A, peer review, UR, etc., that fall within the purview of the medical staff.

- Sources of regulation:
 - CMS hospital conditions of participation;
 - State hospital licensing laws;
 - National accreditation organizations, e.g., the Joint Commission.
- A medical staff committee, frequently the Credentials Committee, reviews a physician's application for privileges; makes a recommendation to the hospital board.
- The board has the final authority concerning whether to accept or deny the application.
- Historically the granting of privileges was based on quality of care; more recently, economic factors may also play a role, e.g., "loyalty criteria," and influences exerted because of "value-based purchasing."

- Medical staff also performs peer review. Peer review includes review of the quality of care or professional competence of individual physicians who are members of the medical staff and who want to become members (e.g., credentialing). “Peer review” can also encompass broader institutional quality evaluations.
- Peer review of individual practitioner:
 - A MS committee performs an investigation.
 - If the committee or the MEC recommends an “adverse action” against the physician, the physician is entitled to a due process hearing (unless summary suspension applies).
 - If the hearing committee affirms the recommendation, it is sent to the hospital board to accept or reject (or remand).

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Basic Antitrust Principles

The Applicable Antitrust Statutes

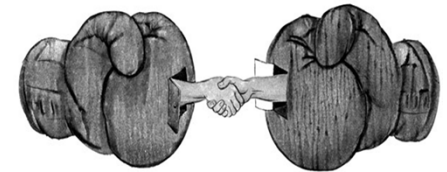
- **Sherman Act §1**
 - Prohibits contracts, combinations and *conspiracies that unreasonably restrain* competition
- **Sherman Act §2**
 - Prohibits **Monopolization**, Attempts to Monopolize, and **Conspiracies To Monopolize**
 - It is not illegal to be a monopoly; only to unfairly obtain or maintain monopoly power
- **FTC Act §5**
 - **Unfair methods of competition**
 - Encompasses conduct prohibited by Sherman Act §1 and §2, but can reach conduct those statutes don't
- **State Antitrust Laws**



But the antitrust allegations can be the tail wagging the dog (e.g., breach of contract, equitable estoppel, tortious interference, tortious conversion, fraud, violation of due process, § 1983, defamation)

Sherman Act § 1

- Agreements that unreasonably restrain competition may be:
 - Horizontal
 - Agreements among competitors
 - Example: Two physicians in the same medical specialty agree to stop a competitor from being granted hospital staff privileges.
 - Vertical
 - Agreements among parties at different supply levels
 - Example: A neurosurgery group on the hospital system's medical staff obtains agreement from the system not to grant privileges to a competitor of the neurosurgeons, effectively shutting off an avenue of practice for the competitor.



The Key Ingredients for a Section 1 Violation

- Two or more parties
- Agreement
- Unreasonable restraint on competition
 - Not all agreements restrain competition
 - Not all competitive restraints are unreasonable
 - Naked – restraint without any "redeeming" purpose
 - Ancillary – reasonably related to the achievement of efficiencies
- Anticompetitive Effects
 - Direct
 - Proof of higher prices, reduced quality or availability of services, or reduced access to care
 - Circumstantial
 - Proof of market power
 - Requires definition of the "relevant market"
 - » Two components: product and geographic markets
 - Based on shares in the relevant market and likelihood of harm to competition
- Procompetitive efficiencies outweighed by the anticompetitive effects



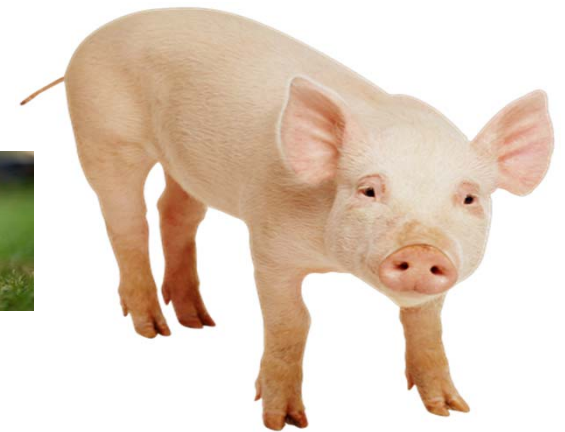
Sherman Act §1 Essential Element: Two or More Parties

- Individual parts of a single enterprise cannot conspire – *Copperweld*, 467 U.S. 752 (1984)
 - Employees and agents who function so closely with their principal that all act as a single enterprise are incapable of a conspiracy in restraint of competition – *American Chiropractic Ass'n v. Trigon Healthcare*
 - Hospital, its board, its officers and its employees generally cannot conspire because they share a unity of purpose, but hospital-employed physicians may have a capacity to conspire if they have an "independent economic interest"
- Is the medical staff a single entity?
 - Generally, no. It's a combination of individuals with independent economic interests capable of conspiring.
 - Practices separate from their connection to the medical staff and are sometimes competitors of each other
- Can a hospital conspire with its medical staff?
 - 9th and 11th Cir. say yes; 3rd, 4th, 6th and 7th Cir. say no in the context of medical staff credentialing
 - *Bolt v. Halifax Hosp. Med. Ctr.*, 891 F.2d 810, 819 (11th Cir. 1990)
 - Rejected analogy to corporation: physicians retain separate economic interests
 - *Oksanen v. Page Mem. Hosp.*, 945 F.2d 696, 703 (4th Cir. 1991)
 - Medical staff acts as hospital's agent, particularly because board retains and exercises ultimate authority
 - *Oltz v. St. Peter's Cmty. Hosp.*, 861 F.2d 1440, 1451 (9th Cir. 1988)
 - Excluded providers coerced board into credentialing/contracting decision



Sherman Act § 2

- Monopolization
 - Must have market power (i.e., ability to raise, and sustain, price above competitive levels)
 - Evidence of price increases or competitor exclusion
 - High market share and barriers to entry
 - Conduct to maintain or enhance market share
 - **Competition**, not merely competitors, **harmed**
- Attempted monopolization
 - High market share
 - Exclusionary conduct with specific intent to build a monopoly
 - Dangerous possibility of success
- Conspiracy to monopolize
 - Need more than 1 actor
 - Same factors as monopolization or its attempt



Unilateral action: Sherman § 2

- It is not illegal to BE a monopoly.
 - Many rural hospitals are “natural monopolies”
- It is only illegal to unfairly obtain or maintain monopoly power.
 - Questions raised in exclusive contract cases where the hospital is the only one available
 - Scrutinized, especially where the medical staff is antagonistic to administration
 - Economic credentialing situations



FTC Act Section 5(a)

- Makes unlawful "unfair methods of competition" and "unfair or deceptive acts or practices"
 - Prohibits practices that violate Sherman Act Sections 1 and 2 and their “spirit”
 - The Commission has expanded the reach of Section 5 to conduct that might not be illegal under the Sherman Act
 - Covers consumer protection, as well
 - Advertising
 - Privacy of information
- Only applicable to for-profit businesses or individuals
- Enforced only by the FTC
 - No private right of action



The Standards for an Antitrust Analysis

- Per Se
 - Conduct automatically illegal, regardless of reason or potential justification
 - Examples: price-fixing and market allocation
- Rule of Reason
 - Full balancing of anticompetitive effects and procompetitive efficiencies
 - Complicated, very fact-specific analysis
 - Example: a tying claim against a hospital and a practice with which it has entered an exclusive contract – *Jefferson Parish Hosp. Dist. v. Hyde*, 466 U.S. 2 (1984)
- Quick Look
 - Q1: Is the conduct of a type that is inherently suspect?
 - Q2a: If not, then rule of reason applies.
 - Q2b: If so, are there plausible and cognizable justifications?
 - Q3a: If not, then conduct illegal.
 - Q3b: If so, then rule of reason applies.



Antitrust Standing

- Three elements
 - Injury in fact (article III standing)
 - Antitrust injury
 - Remoteness



Standing: Antitrust Injury

- The antitrust laws were enacted to protect **competition**, not **competitors**.
 - “[T]he fact that a hospital’s decision caused a disappointed physician to practice medicine elsewhere does not of itself constitute an antitrust injury. If the law were otherwise, many a physician’s workplace grievance with a hospital would be elevated to the status of an antitrust action.”
 - *Oksanen v. Page Memorial Hosp.*, 945 F.2d 696, 708 (4th Cir. 1991) (en banc)
 - No antitrust injury where radiologist lost an exclusive contract in a competitive bidding process
 - *Nilavar v. Mercy Health System-Western Ohio*, 244 Fed. Appx. 690, 699-700 (6th Cir. 2007)
 - Replacing one exclusive provider with another is generally not proof of harm to competition
 - *Coffey v. Healthtrust, Inc.*, 955 F.2d 1388 (10th Cir. 1992)
 - No injury in being denied ability to share in hospital’s monopoly
 - *Four Corners Nephrology Assocs., P.C. v. Mercy Med. Ctr. of Durango*, 582 F.3d 1216, 1221 (10th Cir. 2009)
 - *Todorov v. DCH Healthcare Auth.*, 921 F.2d 1438, 1452-54 (11th Cir. 1991) (“The antitrust laws were not enacted to permit one person to profit from the anticompetitive conduct of another.”)
- But what IS an actionable injury?
 - “If the injury flows from the aspects of the defendant’s conduct that are beneficial or neutral to competition, there is no antitrust injury” *Rebel Oil Co. v. Atlantic Richfield Co.*, 51 F.3d 1421, 1433 (9th Cir. 1995)

Important Defenses and Exemptions

Health Care Quality Improvement Act of

AHILA

42 U.S.C. §§ 1101-52

- Immunity from damages, not injunctive relief
- Immunity from antitrust and common law claims
 - *Poliner*, 537 F.3d 368 (5th Cir. 2008): \$360 million judgment for defamation, reversed on appeal; some defendants settled after trial court denied immunity
- Protects “professional review body”
 - Includes individuals and hospitals, as well as witnesses who provide evidence
 - Doesn’t apply to challenges by non-physician providers (NP, PA, CRNA)
- Protects a “professional review action”
 - Based on competence, professional conduct of a physician
 - Restriction or termination of privileges
 - Non-clinical, “disruptive” actions
 - Does not include actions based primarily on economic considerations (i.e., economic credentialing)
 - Competitive activity (i.e., provider-owned facilities), fees, non-participation with insurers
- Four required elements:
 - Reasonable belief that the action was in furtherance of quality health care
 - Action taken after a reasonable effort to obtain the facts of the matter
 - Action taken after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances
 - Action taken in reasonable belief (i.e., objective) that it was warranted by the known facts

Exemptions and Immunities: State Action

- Federal courts recognize that a state government may adopt a regulatory scheme that supplants free competition, and, in doing so, preempt the application of the federal antitrust laws to conduct in furtherance of the state’s regulatory goals.
- Strongly disfavored by the antitrust agencies and narrowly construed.
- Immunity applies to state governments, as well as to certain of a state’s governmental subdivisions authorized by the state to implement its policies and exercising the delegated authority of the state.
- Elements:
 - Conduct must be “clearly articulated and affirmatively expressed as state policy.”
 - If the entity in question is a state subdivision, then it need only show that the anticompetitive conduct it undertakes pursuant to that policy was foreseeable.
 - If the entity in question is not a subdivision of the state, then a second test applies requiring that “the policy must be ‘actively supervised’ by the state itself.”

State Action Applied to Peer Review and Exclusive Contracts

- Peer Review - *Patrick v. Burget*, 486 U.S. 94 (1988)
 - Dr. Patrick, a general and vascular surgeon, was an employee of Astoria Clinic in Astoria, Oregon. They offered to make him a partner. Dr. Patrick declined and opened a competing practice.
 - Columbia Memorial Hospital is the only hospital in Astoria. A majority of its medical staff are with Astoria Clinic.
 - After complaints by clinic doctors, CMH's medical staff executive committee voted to terminate Patrick's privileges. Patrick demanded a hearing. An ad hoc committee, chaired by a clinic doctor who had complained about Patrick held the hearing. Patrick felt they were biased and resigned.
 - District Court ruled in Patrick's favor under Sherman Act Sections 1 and 2. Ninth Circuit reversed, finding peer review proceedings to be immune under State Action because of an Oregon policy in favor of peer review.
 - Supreme Court HOLDING: the active supervision requirement was not met
 - "Where a private party is engaging in the anticompetitive activity, there is a real danger that he is acting to further his own interests, rather than the governmental interests of the State." *citing Hallie v. Eau Claire*, 471 U.S. 34, 47 (1985)
- *LaFaro v. New York Cardiothoracic Group*, 570 F.3d 471 (2009)
 - Westchester County Medical Center (WMC) entered an exclusive PSA with New York Cardiothoracic Group (NYCG). Plaintiffs, Drs. LaFaro and Fleisher, were grandfathered and allowed to continue providing cardiothoracic surgical services.
 - State created Westchester County Health Care Corporation (WHCC) in 1997 to operate WMC. Enabling statute gave it broad powers to determine the hospital's operating policies and to enter into contracts.
 - Dr. Lansman, a NYCG surgeon, directed scheduling/staffing and severely disadvantaged Plaintiffs, giving NYCG preference.
 - District Court dismissed the complaint, finding State Action immunity applied to all defendants.
 - Second Circuit found hospital authority to enjoy same status as a municipality and the exclusive contract was a foreseeable consequence of WHCC's enabling statute. BUT purporting to act pursuant to the exclusive contract did not exempt NYCG from the active supervision prong and "the mere potential for supervision" was not enough.

The Current State of State Action

- Phoebe Putney Health System
 - Acquisition by a hospital authority and lease to not-for-profit corporation
 - FTC argued that it was not foreseeable under the Georgia statute that hospital authorities would engage in mergers to monopolies
 - Court denied FTC injunction request based on state action; 11th Circuit affirmed; Supreme Court reversed 11th Circuit
 - HOLDING: The statute authorizing the creation of hospital authorities did not clearly articulate or affirmatively express a policy allowing hospital authorities to engage in acquisitions that substantially reduce competition, so the state action doctrine did not immunize the transaction.
- North Carolina Board of Dental Examiners
 - FTC denied motion to dismiss on state action, finding active state supervision is a requirement for the exemption to apply to regulatory agencies comprised primarily of market participants.
 - Dental Board filed a complaint in district court seeking a declaration that the FTC's position was incorrect as a matter of law; District court dismissed the complaint; Dental Board appeal to the 4th Cir.; 4th Cir. affirmed the FTC's position; *cert* granted by the Supreme Court
 - ISSUE: Is a state licensing and regulatory board a private actor—and, therefore, subject to the active supervision prong—if a majority of the board's members are currently practicing professionals who are elected to their board seats by other practicing professionals?

Local Government Antitrust Act of 1

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15 U.S.C. § 34-36

- "No damages, interest on damages, costs or attorney's fees may be recovered...from any local government, or official or employee thereof acting in an official capacity."
 - The term "local government" includes "any other special function governmental unit established by State law" (e.g., hospital authorities and public hospital districts)
 - BUT, a public trust hospital did not qualify-*Tarabishi v. McAlester Reg'l Hosp.*, 951 F.2d 1558 (10th Cir. 1991)
 - Local government official includes board members, administrators and staff
 - *Crosby v. Hosp. Auth. of Valdosta*, 93 F.3d 1515 (11th Cir. 1996)
 - Doctors participating in peer review decisions may qualify as individuals "acting in an official capacity" if the two prongs of the state action test
 - Clear articulation
 - Active supervision
 - *Cohn v. Bond*, 953 F.2d 154, 158 (4th Cir. 1991) (immunity for peer review participants)
 - No financial damages, but permits a finding of liability and granting of injunctive relief

Credentialing and Peer Review

Credentialing and Peer Review

- Types of Decisions - Hospitals, MCOs, ACOs, CINs
 - Denial of Application/Initial Appointment
 - Under “Rule of Non-Review” most state courts do not exercise jurisdiction to review denials and applications or initial appoints (See, e.g., Adkins v. Sarah Bush Lincoln Health Center, 129 Ill. 2d 497 (1989))
 - There is no constitutional or legal right to be on a hospital medical staff, an ACO or an MCO
 - For an MCO there may be a state “any willing provider” requirement

Credentialing and Peer Review (cont'd)

- It is becoming more common to screen out physicians and other providers when:
 - They are employed by a competitor
 - Their practice was purchased by a competitor
 - They are an owner, investor or has a financial interest in a competing facility
 - Their “report card” reveals a history and/or pattern of over-utilization and poor quality outcomes
 - They serve in a leadership position, i.e., Department Chair, Medical Director or Board member or have an exclusive or similar contract with a competitor hospital, ACO, etc.
- These providers are not entitled to a hearing but the decision is not reportable to the Data Bank

Credentialing and Peer Review (cont'd)

- In Illinois, hospital has to send in an anonymous report when it makes an adverse decision based on economic factors unrelated to a physician's competency, training or education (210 ILCS 85/10.4(b)(3))
- Adverse Membership/Clinical Privilege Decisions
 - Non-Reappointment
 - Poor Quality
 - Over-utilization
 - Disruptive behavior
 - Non-compliance with standards
 - Hospital enters into a new exclusive contract for hospital-based, testing, ED call or other services

Credentialing and Peer Review (cont'd)

- Reduction in membership, privileges or staff category
- Terminations
- Suspensions and summary suspensions
- Mandatory consultations requiring prior approval
- Excluded from MCO/ACO but remain a member of medical staff
- Prohibited from treating certain patient populations, i.e., HMO, Medicare patients in ACO, but still a member of medical standards
- Removal from ED call – duty not a privilege
- Removal from physician referral list
- Not eligible for Medical Staff leadership or Board positions due to economic conflicts of interest
- Competing physician has membership on one Medical Staff but not allowed membership on other System Medical Staffs, MCOs, ACO

Conduct to Mitigate Against Antitrust and Related Legal Claims

- Types of Legal Challenges
 - Antitrust
 - Breach of contract
 - Tortious interference with existing and prospective business relationships
 - Violation of due process
 - Defamation
 - Discrimination based on age, sex, race, religion, disability
 - Interference with physician/patient relationships

Conduct to Mitigate Against Antitrust and Related Legal Claims (cont'd)

- Denial of Application Request
 - Should be based on Board adopted policy, such as a Medical Staff Development Plan, Needs Assessment Policy, etc., and implemented as an administrative matter
 - Policy should be tied to quality of care, availability of resources such as staffing, equipment and supplies, space, etc. Adverse financial considerations also can be a factor
 - Physicians and competitors should not be allowed to veto or otherwise decide who does and does not receive an application
 - Courts have held that when medical staffs and others simply make a “recommendation” versus a final decision, they are treated as “agents” of the hospital and therefore cannot conspire to illegally restrain competition in violation of Section 2 of the Sherman Act (See, e.g., Oksanen v. Page Memorial Hospital, 945 F.2d 696 (4th Cir. 1991); Patel v. Scotland Memorial Hospital, 91 F.3d (32 (4th Cir. 1996))

Conduct and Recommendations to Mitigate Against Antitrust and Related Legal Claims

- Always comply with your Medical Staff, ACO, and MCO policies and make sure procedures are fair
- Comply with HCQIA procedural and hearing standards (see discussion Supra)
- Denials of Initial Appointment
 - Same recommendations as above
 - Important for Board to make final decision tied to a legitimate grounds such as not meeting standards, no need, lack of resources, etc.
 - Keep in mind that denials based on concern that physician could have an adverse impact on patient care is reportable to Data Bank
 - Should provide an explanation for the decision
 - Hearing for denial of application?
 - Hearings not required in most jurisdictions

Conduct and Recommendations to Mitigate Against Antitrust and Related Legal Claims (cont'd)

- Denials of initial appointments are almost never reportable, but if required, then consider offering a hearing in order to receive antitrust and other immunity protections provided under HCQIA and possibly state law
- If denial based on factors unrelated to quality or potential adverse impact on patients, then HCQIA protections would not apply
- As a professional courtesy contact physician to allow them opportunity to withdraw application so as to avoid denial decision
- Application forms and Bylaws should include following provisions:
 - Absolute release and waiver of liability language (see attached examples)
 - Immunity provisions (see attached bylaw example. See also Botvinick v. Rush University Medical Center, 574 F.3d 414 (7th Cir. 2009))
 - Burden to produce all requested information or else application considered withdrawn (see attached bylaw example)

Conduct and Recommendations to Mitigate Against Antitrust and Related Legal Claims (cont'd)

- ACOs and MCOs have the ability to qualify as “health care entities” under HCQIA but must
 - Query at time of appointment, reappointment and when physician is seeking additional protections
 - Must report certain final adverse decisions
 - Must adopt and follow a hearing process which satisfies HCQIA standards
- See attached letter from Data Bank

Conduct and Recommendations to Mitigate Against Antitrust and Related Legal Claims (cont'd)

- Adverse Decisions While a Member
 - Make sure you follow applicable bylaws and peer review policies leading up to adverse decision
 - Attempt to first implement “collegial intervention” or similar remedies to avoid hearing, loss of privileges and reports (see attached example)
 - Can physician still resign without a Data Bank or state report?
 - Reportable actions, aside from involuntary termination, suspension, reduction in privileges and mandatory consultations requiring prior approval, include:
 - Resignations in lieu of corrective action
 - Resignations while “under investigation”

Conduct and Recommendations to Mitigate Against Antitrust and Related Legal Claims (cont'd)

- Monitoring, proctoring, FPPE plans (but see new draft NPDB Guidebook), mandatory consultations and other lesser remedial measures do not require a NPDB report
- Will physician resign under a negotiated Data Bank report?
- Was action taken consistent with Medical Staff, ACO/MCO peer review, quality and HCQIA standards?

Other Defenses and Protections

- Antitrust and Non-Discrimination Claims
 - HCQIA Immunity Protection
 - See discussion Supra; Poliner v. Texas Health Systems, 537 F.3d 368 (5th Cir. 2008)
 - Except for Title VII and other federal discrimination claims, HCQIA applies to other causes of action aside from antitrust in federal and, if the state adopted HCQIA, state claims
 - HCQIA does not provide peer review confidentiality protection from discovery or admissibility into evidence

Other Defenses and Protections (cont'd)

- State Immunity Protections
 - Most state statutes have a qualified immunity protection as applied to decisions based on peer review, quality and risk management decisions
 - Illinois: 210 ILCS 85/10.4(a)
 - Missouri: Mo. Rev. Stat. §537.035.3
 - Georgia: GA. Code Ann. §31-7-132(A)
 - These statutes, however, do not necessarily apply if decisions are based solely on economic factors which are not linked to protected activities
- Judicial Deference to Corporation's Exercise of Reasonable Business Judgment
- Inability to Conspire under Section 2 of the Sherman Act
 - See Oksanen, Patel, infra.

Other Defenses and Protections (cont'd)

- State Confidentiality Statutes
 - Most state statutes do not allow the discovery or admissibility into evidence of any information, reports, studies or analyses relating to covered peer review, quality, risk management and patient safety activities
 - If not discoverable or admissible then physician has little or no evidence to sustain cause of action
 - Carson v. Northwest Community Hospital, 92 Ill. App. 3d 118 (1989) (citing to prohibition of introducing protected peer review information into evidence under Illinois Medical Studies Act (735 ILCS 5/8-2101), appellate court affirmed trial court's dismissal of state antitrust lawsuit)

Other Defenses and Protections (cont'd)

- These protections do not generally apply to pre-empt federal claims in federal court where antitrust, discrimination and other federal causes of action are alleged but will apply to pendant state claims, i.e., defamation, tortious interference
 - See, e.g., Adkins v. Christie, 488 F.3d 1324 (11th Cir. 2007)
- Federal Confidentiality Statute
 - Patient Safety and Quality Improvement Act of 2005 (42 USC ch. 6A, subch. VII part C)
 - PSQIA enables all licensed providers in a state to create or contract with a Patient Safety Organization (“PSO”) which is certified by the Agency for Healthcare Research and Quality (“AHRQ”)

Other Defenses and Protections (cont'd)

- Reports, data, analyses, discussions and other documentation which is relating to patient safety activities, i.e., peer review, quality management, risk management, and are collected for reporting to a PSO are strictly privileged and confidential and not subject to discovery or admissibility into evidence in state or federal proceedings
- PSQIA is the first federal peer review confidentiality statute
 - IDFPR v. Walgreen, 2012 Il. App (2d) 11042. Appellate court affirmed trial court's dismissal of lawsuit filed by Illinois Department of Financial and Professional Regulation against Walgreen which refused to turn over medication error incident reports because these had been collected and reported to Walgreens' component PSO. Court agreed that the PSQIA pre-empted state law that would have permitted discovery of the reports and that Walgreen demonstrated compliance with PSO requirements

Exclusive Contracting/Closure of Medical Staff

Exclusive Contracting/Closure of Medical Staff

- Exclusive contracting is typically utilized by a hospital for hospital-based services, such as radiology, pathology and anesthesiology
- Under this arrangement a physician group is given the exclusive franchise to provide these services for a defined period of time
- Hospital will not consider granting physician applications to join the group unless group has decided to first contract with the physician
- Primary reasons why courts have universally upheld these arrangements and have turned down antitrust and other challenges is a recognition that exclusive groups promote continuity of care, 24/7 coverage, greater efficiencies and overall improvement of health care services

Exclusive Contracting/Closure of Medical Staff

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- BCB Anesthesia Care, Ltd. V. Passavant Memorial Area Hospital Associates, 36 F.3d 667 (7th Cir. 1994)
- Lyons v. St. Vincent Health Center, 731 A.2d 206 (1999)
- Holt v. Good Samaritan Hospital and Health Center, 69 Ohio App. 3d 439 (1990)
- Jefferson Parish Hosp. Dist. V. Hyde, 466 U.S. 2 (1984)
 - Case involved a challenge to an exclusive contract for anesthesia services

Exclusive Contracting/Closure of Medical Staff

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- Plaintiff alleged that agreement created a per se illegal tying arrangement in violation of Section 1 of Sherman Act
 - Under a rule of reason analysis, although the Court found that the contract did create a tying arrangement between the hospital's surgical facilities and anesthesia services, the hospital's 30% market share in surgery services did not give it sufficient market power to force patient to purchase anesthesia services
- Some states specifically allow the use of exclusive contracts
- Illinois: 210 ILCS 85/10.4(b)(2)(C)(iii)

Exclusive Contracting/Closure of Medical Staff

- Practical Issues, Consideration and Recommendations
 - Does agreement contain “clean sweep” provision whereby group and physicians waive hearing rights if contract terminated?
 - If so, does contract term conflict with Medical Staff Bylaws or state law regarding access to hearing rights?
 - Best practice is for the contract and Bylaws to be consistent on this point (see example bylaw provision)
 - Consider use of an administrative proceeding different from a Medical Staff bylaws hearing

Exclusive Contracting/Closure of Medical Staff

- If hospital entering into an exclusive arrangement for the first time, need to consider:
 - Impact on existing physicians
 - Explaining need for exclusive arrangement with MEC
 - Provide sufficient prior notice and availability of hearing rights
 - Decision should be Board driven with identification of pro-competitive and quality of care considerations

Exclusive Contracting/Closure of Medical Staff

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- Are the bylaws considered a contract in your state?
 - Is there existing case law which addresses a conflict which suggests terminated physician entitled to a hearing irrespective of contract language?
 - See, e.g., Lawler v. Eugene Wuesthoff Memorial Hospital Association, 497 So. 2nd 1261 (Fla. Dist. Ct. App. 1986)
 - See, also, Robles v. Humana Hospital Cartersville, 895 F. Supp. 989 (N.D. Ga. 1992) (Bylaws controlled even though not considered a contract)

Exclusive Contracting/Closure of Medical Staff

- Is your hospital considered an “essential facility” that may affect whether any exclusive arrangement is enforceable or the scope and number of such arrangements?
 - There is no real clear definition as applied to a hospital setting particularly in today’s environment
 - Is a relevant issue, however, where hospital is sole provider in defined geographic market – must look to services/product lines affected
 - Some courts have held that this doctrine should not be applied to medical staff decisions based on public policy considerations
 - Pontius v. Children’s Hospital, 552 F. Supp. 1352 (W.D. Pa. 1982)
 - Robles, see supra
 - Need to look at facts and circumstances of situation and whether there are lesser restrictive means of achieving patient care benefits

Exclusive Contracting/Closure of Medical Staff

- If hospital decides to terminate a member of an exclusive group based on quality of care concerns should this physician be reported to the Data Bank?
 - Although not considered reportable unless part of hospital and medical staff's professional review action, out of fairness to the physician and in order to access HCQIA community protections, hospital should consider providing a hearing even if not required under the contract

- Hospital-Provider Joint Ventures

- Two kinds generally attract the most antitrust concern:
 - When hospitals and physicians own a facility that provides outpatient services, e.g., an ASC, Lab, IDTF, etc.
 - When hospitals and physicians form an integrated network, e.g., a PHO or ACO, or clinically integrated network.
- The issue here is whether joint negotiation of price-related terms with payers violates Section 1 of the Sherman Act.

- Single economic entity?
 - How much of the JV must the hospital own or control for the JV to be “Copperwelded?”
- Partial integration
 - Copperweld will include employed physicians, but not a network including “community” or “independent” physicians or physicians in “private practice.”

- Partial integration
 - Financial integration
 - Health Care Statement 9: “sharing substantial financial risk.”
 - Mentions capitation, percentage of premium, withholds, and global fees-
- could also include some of the more recently-discussed value-based payment arrangements, e.g., shared savings with downside risk, bundled payments, etc.
 - “The Agencies recognize that new types of risk-sharing arrangements may develop. The preceding examples do not foreclose consideration of other arrangements through which the participants in a multiprovider network joint venture may share substantial financial risk in the provision of health care services or products through the network.”

- Partial integration
 - Clinical integration
 - Health Care Statement 9.
 - FTC Advisory Opinions:
 - Norman Physician Hospital Organization (2013)
 - TriState Health Partners (2009)
 - Suburban Health Organization (2006)
 - Non-exclusivity an important consideration
 - The “Messenger model.”

- Partial integration
 - ACO guidance (Medicare Shared Savings Program). Rule of Reason applicable to MSSP ACOs that meet the following eligibility criteria:
 - (1) a formal legal structure that allows the ACO to receive and distribute shared savings;
 - (2) a leadership and management structure that includes clinical and administrative processes;
 - (3) processes to promote evidence-based medicine and patient engagement;
 - (4) reporting on quality and cost measures; and
 - (5) coordinated care for beneficiaries.

- Partial integration
 - “In light of CMS’s eligibility criteria, and its monitoring of each ACO’s results, the Agencies will treat joint negotiations with private payers as reasonably necessary to an ACO’s primary purpose of improving healthcare delivery, and will afford rule of reason treatment to an ACO that meets CMS’s eligibility requirements for, and participates in, the Shared Savings Program and uses the same governance and leadership structures and clinical and administrative processes it uses in the Shared Savings Program to serve patients in commercial markets.”
- More than 360 MSSP ACOs.

- Hospital acquisition of physician practices
- Subject to Clayton § 7
- Even if not subject to HSR Reporting
 - Spokane, WA (2011): FTC challenged proposed acquisition of two cardiology clinics
 - Harrisburg, PA (2011): Penn. AG consent decree with 13 urologists
 - Boise, ID (2014): St. Luke's Health System, Ltd, and Saltzer Medical Group, P.A.

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