

PRACTICAL HEALTHLAW



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SEPTEMBER/OCTOBER 2009

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Keep your exclusive contracts with hospital-based physicians legitimate

Hospitals nationwide routinely enter into exclusive agreements with physicians and physician groups for certain hospital-based physician services, such as anesthesiology, radiology, pathology, and emergency room medical services.

But hospitals and physicians shouldn't enter into these arrangements without considering the ramifications of the agreement's exclusive provisions. Here are some aspects to think about.

WHY ENTER INTO AN EXCLUSIVE CONTRACT?

Hospitals and physicians typically enter into exclusive agreements to increase the hospital's efficiency and quality of care. Exclusive agreements for hospital-based physicians can ensure continual coverage, standardization of procedures and efficient use of equipment.

These contracts can also allow hospitals to more effectively monitor the quality of services provided by the physicians. Finally, exclusive agreements provide the exclusive providers with an opportunity to grow their practice and focus on the quality of services that they provide.

WHAT ABOUT ANTITRUST CONCERNS?

While exclusive agreements have become relatively common, using exclusive agreements can have a dramatic impact on those physicians who aren't granted exclusive privileges. In effect, the exclusive agreement eliminates their ability to continue their medical practice at the hospital. As a result, some disenfranchised physicians have filed lawsuits, arguing that exclusive agreements raise antitrust issues.

Courts in most jurisdictions have upheld exclusive agreements as being reasonable if they reflect legitimate purposes related to the hospital's operation. Some legitimate reasons for implementing an exclusive agreement include:

- The desire to increase management efficiency,
- The need to improve or maintain the quality of care provided by physicians in a particular department,
- The desire to improve administration of hospital department resources, including staff scheduling,
- The need to assure continuous, uninterrupted coverage, and
- The promotion of standardization of clinical procedures and techniques.

To further insulate the exclusive agreement from a successful antitrust challenge, an agreement's initial term should ideally be less than three years, with either party having the ability to terminate the



Don't run afoul of the Stark law

For years hospitals and physicians have routinely entered into exclusive agreements for the provision of certain hospital-based physician services. These agreements typically contain provisions whereby the hospital provides the space, equipment, maintenance and other supporting services necessary to operate the department. Until the 2009 decision in *U.S. ex rel. Kosenske v. Carlisle HMA, Inc.*, hospitals and physicians weren't overly concerned with the potential Stark Law implications of such agreements.

In *Kosenske*, the hospital and physician group entered into an exclusive agreement for the provision of anesthesiology services at the hospital. Shortly thereafter, the parties expanded both the services provided by the physicians and the location at which they provided such services without amending the exclusive agreement to reflect the changed nature of the parties' relationship.

The court found that, due to the subsequent changes in the parties' relationship, the exclusive agreement was insufficient to satisfy the personal service exception of the Stark Law, because the agreement didn't account for the additional services being provided by the physicians and the increased benefits the physicians received as a result of the changes in the relationship between the parties. As such, their arrangement implicated both the Stark Law and the Anti-Kickback Act.

While *Kosenske* has certainly raised an important issue, hospitals and physicians can avoid the same result by accurately documenting the nature of their arrangement in writing and accounting for all remuneration paid to the physicians under the agreement.

agreement with 90 days' notice. Longer terms may be possible, but will require justification based on specific facts and circumstances.

Hospitals also should conduct periodic reviews of the continuing justifications for the exclusive agreement and should have the ability to terminate the agreement if the justifications are no longer present. Before implementing or renewing an exclusive agreement, a hospital should look at the geographic market in which the hospital provides health care services and determine whether the excluded providers are substantially foreclosed from providing their services anywhere else in the geographic market. This analysis helps define the arrangement's impact on competition for the underlying physician services.

HOW SHOULD YOU IMPLEMENT AN EXCLUSIVE CONTRACT?

You can mitigate the risks of litigation associated with exclusive contracts by following established and tested procedures. First, your hospital's board of directors should carefully evaluate the benefits and drawbacks of an exclusive agreement and determine whether it can achieve the quality, financial and administrative benefits desired.

If the answer is yes, the hospital's board should adopt a written policy detailing the process *before* implementing the agreement. Make sure your policy establishes the justification for entering into exclusive agreements and the protocol that hospital's management must follow when determining its recommendation on whether the proposed agreement is in furtherance of quality care.

Once the board adopts the policy, it's up to the hospital's leadership to implement the policy's strategy and identify areas of need, including potential physicians or physician groups who can fill those needs. The board's policy should guide all discussions with potential exclusive providers, and the board should make the final decision on whether to implement the exclusive agreement.

MOVING FORWARD

Exclusive contracts can be an efficient way to improve your hospital's quality of care. Be sure to implement a policy that establishes not only the *process* of how to enter into an exclusive agreement, but sets forth the *legitimate* reasons for entering into the agreement. By doing so, hospitals and their physician counterparts can strengthen their defense in the event that the exclusive agreement is challenged on antitrust grounds. ■

Independent contractors and direct patient care

Joint Commission introduces a new standard

The Joint Commission is an independent, nonprofit organization that accredits and certifies health care organizations and programs. Recently, the Commission introduced Standard LD.04.03.09 as part of a larger effort to increase the quality of health care. If fully implemented, it will require accredited hospitals to exert greater oversight on independent contractors hired to provide direct patient care.



RESPONSIBILITY FOR QUALITY OF CARE

According to the Joint Commission Manual, the standard's intent is to ensure that the same level of care is provided to patients regardless of whether services are provided directly by the hospital or through contractual agreements.

Because a hospital's leaders are responsible for ensuring that services provided directly by the hospital are safe and effective, they also should be responsible for the quality of care provided through contracted services.

CONTRACTING SUBJECT TO NEW STANDARD

Only those contractual arrangements related to the provision of care, treatment and services provided to a hospital's patients are subject to the standard — for example, when your hospital contracts with a physician who performs anesthesiology services to hospital patients.

The standard *does not* apply to contracted services that aren't directly related to patient care and contracts for consultations or referrals.

But depending on the nature of the services provided, such contracts may be subject to other Commission standards. That means you'll need to review each contract to make sure it complies with the Joint Commission Manual.

EVALUATING QUALITY OF SERVICE

The elements of performance under the standard don't prescribe the methods for evaluating services. Instead hospital leaders are expected to select the best methods for their hospital to oversee the quality and safety of services provided through contractual agreements.

In any evaluation, hospital leaders should set expectations for contracted services that reflect the basic principles of risk reduction, safety, staff competence and performance improvement. To this end, the Commission suggests the following when evaluating contracted services:

- Review information about the contractor's Joint Commission accreditation or certification status.
- Directly observe the contractor's provision of care.
- Review the contractor's documentation, including medical records, any incident reports, and periodic reports submitted by the individual or hospital providing services.

- Collect data that addresses the efficacy of the contracted service and review performance reports based on indicators required in the contractual agreement.
- Gather and review input from staff and review patient satisfaction studies.
- Review results of risk management activities.

In the event contracted services don't meet expectations, hospital leaders should take steps to improve care, treatment and services. This may include the renegotiation or termination of the contract.

SATISFYING THE ELEMENTS OF PERFORMANCE

So what should hospitals consider to ensure their contractual arrangements comply with the new standard? Generally, contractual arrangements related to patient care should establish the provider's qualifications, require a background check, contain a requirement for continued medical education and require the provider to comply with all quality assurance measures established by the hospital. Hospitals should also consider inserting a paragraph in the contract requiring the physician to follow the hospital's bylaws and participate in patient safety and quality assurance programs.

All contracts directly related to patient care should specify the nature and scope of services to be provided by the third-party provider.

In addition, the Commission suggests hospitals have a:

Contract review policy. This includes leadership reviews and approvals of all contractual arrangements between the hospital and third-party providers.

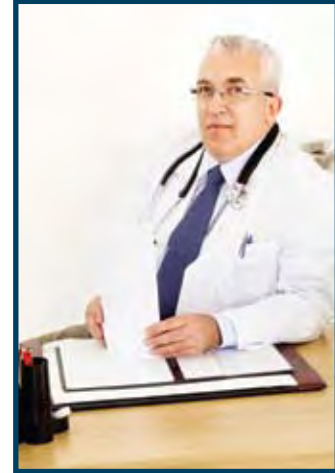
Medical staff review. The hospital's medical staff should review all contracts directly related to patient care so they're aware of the nature and scope of the services provided by the third-party provider.

Credential check. Make sure all independent providers providing services under a contractual agreement are licensed, qualified and properly credentialed. This includes having the necessary privileges at the hospital to perform the services set forth in the contract.

Scope of contract. All contracts directly related to patient care should specify the nature and scope of services to be provided by the third-party provider.

Critique of provided services. Routinely evaluate all third-party providers providing patient care services and establish expectations for the performance and quality of the services in the contractual agreement.

Means for gauging patient satisfaction. To ensure that third-party providers are providing quality patient care, monitor patient satisfaction, review incident reports and audit medical records. Also review any other information that relates to the third-party provider's quality or efficacy of services.



Finally, make sure all contracts directly related to patient care require the third-party provider to comply with all Joint Commission Standards and federal, state and local laws and regulations.

TERMINATING AN AGREEMENT

If a third-party provider fails to meet the expectations and standards set by your hospital, you have several options depending on the degree of failure. The hospital can increase its monitoring of the contracted services or provide consultation or training to the provider. For more serious breaches, the hospital may choose to apply penalties detailed in the contract or terminate the contract if the services are unsatisfactory.

If your hospital decides to terminate a contractual arrangement with a third-party provider, have steps in place to ensure the continuity of patient care.

MEETING THE STANDARD

Your hospital's leadership should actively oversee the Joint Commission's elements of performance for this new standard. The 2009 Joint Commission Clinical Contract Management Review Checklist can help you determine whether your current policies and procedures are sufficient to satisfy the Commission's standards related to services provided through contractual agreements. To obtain the checklist, contact the Joint Commission (jcrinc.com). ■

Revisiting FICA tax and medical residents

Physicians and hospitals are well aware of the FICA tax and its relationship to the Social Security system. But while this concept may seem relatively straightforward, the student exception to the FICA tax (which means a student and his or her employer are exempt from having to pay the FICA tax) has resulted in a firestorm of litigation. The student exception exempts from FICA taxes “services performed in the employ of a school, college, or university if such service is performed by a student who is enrolled and regularly attending classes at such school, college or university.”



MEDICAL RESIDENT CHALLENGES

Do medical residents working in a hospital setting qualify for the student FICA exception? This issue was first raised in *State of Minnesota v. Apfel*, which concluded that medical residents weren't employees for Social Security purposes. The court held that eligibility for the exception depended on a case-by-case examination of whether the resident's relationship with the hospital was primarily for educational purposes or to earn a living.

If the main purpose is to pursue a course of study rather than to earn a livelihood, the resident would be considered a student and the work wouldn't be considered employment.

The *Apfel* decision started a wave of litigation over the status of medical residents for FICA tax purposes. Courts in three other federal circuits also concluded that a case-by-case analysis is required to determine whether a medical resident is a student and whether the hospital at which they perform services can be considered a school, college or university for purposes of the FICA student exception. Generally, the courts found that the patient-care services provided by residents in residency programs were incidental to and for the purpose of pursuing a course of study in postgraduate medical education and that the clinical setting is the classroom for medical residents.

IRS RESPONSE

After losing several cases involving medical residents and the FICA student exception, the IRS amended its regulations governing the student exception. The amended regulations became effective for any services performed after April 1, 2005.

The amended regulations created a primary function test to determine whether an organization is a school, college or university and added new subsections that require an individual to be enrolled and regularly attending classes in a course of study at a college to be eligible for the FICA student exception. The amended regulations seem to all but foreclose the ability of a medical resident to qualify for the FICA student exception.

CURRENT FICA STUDENT EXCEPTION

Only one case has analyzed the amended FICA student exception. In *Mayo Foundation for Medical Education and Research v. United States*, the district court held that the IRS's amended interpretive regulations were invalid and noted that the IRS's

authority to issue regulations doesn't give it the power to make new law.

The IRS appealed this decision. On appeal, the Eighth Circuit held that the regulations were consistent with the statute, and full-time employees didn't qualify for the student exception. Therefore, medical residents who worked full time were subject to FICA taxes.

THE ROAD AHEAD

The Court of Appeals' decision in *Mayo* has significant implications on the ability of a medical resident to qualify for the FICA student exception. Because few medical residents work part time, it will be difficult for medical organizations and their medical residents to qualify for the FICA tax exception. ■

SHOULD ECONOMIC CREDENTIALING BE PART OF YOUR STAFF REVIEW?

As the health care market becomes increasingly competitive, hospitals are often considering more than just the clinical background of its physicians. In fact, some hospitals have begun to review individual physicians' personal financial investments to determine whether a doctor has an economic interest in competing health-related businesses. This "economic credentialing" is becoming more common and can impact both hospitals and physicians.

The AMA defines economic credentialing as the use of economic criteria unrelated to quality of care or professional competence in determining qualifications for initial or continuing medical staff membership or privileges.

As the popularity of physician-owned specialty hospitals has increased, a number of hospitals have implemented more restrictive economic credentialing policies. For example, some hospitals have policies that terminate a physician's medical staff privileges if they own a direct or indirect interest in a competing hospital.

Doctors have routinely taken the position that economic credentialing is anticompetitive and can reduce a hospital's quality of care. Thus the increase in more restrictive credentialing has led to an increase in litigation.

In a case earlier this year, *Murphy v. Baptist Health*, the Arkansas Circuit Court reviewed the validity of Baptist Health's economic credentialing policy. It provided that "no practitioner who, directly or indirectly, acquires or holds an ownership or investment interest in a competing hospital shall be eligible to apply for initial or renewed appointment or clinical privileges in the Professional Staff of any Baptist Health hospital."

The plaintiff was a group of physicians who owned an interest in a local private acute-care hospital specializing in cardiac care. They claimed the policy tortiously interfered with the physician-patient relationship. In defense of the policy, Baptist Health argued that it was implemented to prevent physicians from selectively referring profitable patients to their own facilities while dumping unprofitable patients on Baptist Health.

Ultimately, the court held that Baptist Health's economic credentialing policy did interfere with the physician-patient relationship and constituted an unconscionable trade practice. It also found that the policy negatively affected the quality of patient care by limiting healthy competition between providers.

Hospitals that currently have or plan on implementing a similar policy should discuss with their legal counsel the implications of this case, if any, on their economic credentialing policy's validity.



A message to our clients and friends:

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We understand the value of good information when making sound business decisions. *Practical Health Law* is written by Hall Render's health law attorneys, each with extensive experience handling the legal issues of health care providers. We trust the information in each issue will be a valuable resource. Our attorneys stand ready to respond promptly to your questions and needs; please contact us if there are specific topics you would like to see addressed.

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