MHA Comments on Economic Credentialing & Conflict of Interest Legislation
March 6, 2008

Introduction
Hospitals and physicians are natural allies. Both are dedicated to ensuring access to high quality medical treatment, and both are dedicated to building a strong health care infrastructure in their communities.

However, in today's health care environment, these mutual interests are increasingly being obscured as a result of recent trends in the financing of health care, market forces and the changing ways physicians choose to practice. Some physicians seek ownership interests in health care and services while others seek an employment relationship rather than an independent practice.

Because of these emerging trends we find ourselves in a competitive position. It's made all the more difficult when a physician has one foot in each camp.

The Legislature's debate in 2007 on SB 312 illustrates just how divisive these issues can become.

Throughout the Legislature's deliberations, MHA has held one overriding objective: to preserve the ability of hospital boards to set policies governing all aspects of the operations of the facility.

Preserving this ability is necessary for hospitals to remain in compliance with the Medicare Conditions of Participation (COP), which give the board of a non-profit, community hospital final authority to ensure that the hospital fulfills its mission, that the hospital's assets are used wisely and that the facility's financial resources are managed responsibly.

The COP also specifies that the board's responsibilities include addressing the operations of the hospital and appointing members of the medical staff.

The development of physician-owned facilities and ancillary services has raised a new set of challenges for hospital boards and management and physicians. These challenges focus on the conflicts of interest that arise when physicians hold an ownership interest in a health care facility or service that competes with the community hospital.

As part of their responsibility to govern the hospital and oversee the wise use of its resources, hospitals have to be able to establish policies that allow them to handle these conflicts of interest. In general, these conflicts arise in three situations:

- When a member of the Board of Trustees holds an interest in an entity or organization that competes with the hospital in some way;
- When a physician with an interest in a competing enterprise serves in a medical staff leadership position; or
- When a physician with an interest in a competing enterprise refers patients for additional services that are provided by the entity in which he or she holds an interest.

SB 312 allowed hospitals – at their discretion – to exclude physicians with a conflict of interest from positions on the board of trustees or medical staff leadership. It is important to note that this exclusion is not mandatory; but, rather, an option the hospital can use if it believes the conflict of interest would be detrimental to its interests.

The SJR 15 study was authorized to determine appropriate public policy in this area in the future.

MHA has prepared a draft bill that represents a starting point for discussions with physicians and other stakeholders. This bill is summarized below; a copy of the legislative language is attached.

We offer one caveat. This is an MHA staff draft and NOT a draft endorsed by the MHA Board of Trustees. MHA staff will circulate this draft to its members for review and comment. Based on input from MHA members, the board will recommend appropriate modifications.

Draft Credentialing & Conflict of Interest Bill

Section 1. Section 50-5-105 MCA. Prohibition of discrimination.

- **MHA proposes** to delete (4) from this section and to delete the provisions that would apply after July 1, 2009.
- **Rationale**: This section prohibits discrimination against anyone "based on race, creed, religion, color, national origin, sex, age, marital status, physical or mental disability, or political ideas." In MHA's view, this wasn't intended to be invoked in disputes involving physician credentialing and conflict of interest. Remedies for violations of 50-5-105 is action by the human rights commission, which, in our view, is not an appropriate body to act on credentialing and conflict of interest questions.

Section 2: Section 50-5-117, MCA. Economic credentialing of physicians prohibited.

- **MHA proposes:**
    - Making permanent the prohibition on economic credentialing enacted in SB 312 and contained in (1) of the MHA draft.
    - In (3)(b), adding a definition of "conflict of interest" using language generally accepted in the business environment.

- In (3)(c)(iv), authorizing hospitals to take disciplinary action "where a physician or physician group engages in abusive referral patterns based on a patient's health insurance coverage or ability to pay."
    - Disciplinary action could not be taken unless an abusive referral pattern has been determined by a third-party, i.e. an arbitrator.
    - MHA proposes language that would require both parties in an arbitration to be forthcoming with data to substantiate their case.

- **Rationale**:
    - MHA members do not object to continuation of the prohibition on economic credentialing.
    - However, they do want an avenue for taking disciplinary action in the event a physician takes actions that undermine the financial health of the facility.
    - By requiring a third-party arbitrator, we believe both the hospitals' interests and the physician's are protected.
    - Regardless of the mechanism for determining an abusive referral pattern, the linchpin is accurate referral data.
    - As in SB 312, exclusion of physicians with a conflict of interest from positions on the board of trustees or medical staff leadership is not mandatory; it is at the discretion of the hospital. Exclusion or disciplinary action is an option the hospital can use if it believes the conflict of interest would be detrimental to its interests.

Section 3: Section 50-5-207, MCA. Denial, suspension or revocation of health care facility license.

- This section authorizes the Department of Public Health and Human Services to take action if hospitals violate the requirements included in these sections codified in Title 50.
- The MHA draft removes the sunset provision, making this section permanent.

Section 4: Section 37, MCA. Disclosure

- One of the new issues raised by the SJR 15 subcommittee has been disclosure of conflicts of interest by a referring physician.
- In its February 21 draft of LC 0038, Legislative staff included provisions that would require referring physicians to notify patients of a conflict of interest and treatment location options. This is an issue for physicians and other health care providers to decide.
- Our only suggestion in this area is to codify provisions that affect health care providers should in Title 37, which addresses professional licensure. This ensures that violations of the statutory requirements can be addressed by the relevant licensure boards. That suggestion is reflected in our draft.
- Note that federal rules published in August 2007 include a number of disclosure requirements for physicians who hold financial interests in health care facilities.

What's Not in the MHA Draft?

- **Section 1 (3) of LC 0038 February 21 draft is deleted**. This provision affected hospital facility scheduling and on-call policies. MHA proposes its deletion because the language about "punishing" an independent physician is too vague and would only come into play after an arbitrator determined that the physician was engaged in an abusive referral pattern. Presumably, a physician removed from the medical staff would not continue to access hospital facilities or be part of a call schedule.

- **Section 3 (3) of LC 0038 February 21 draft is deleted**. While it's hard to argue with the sentiment, MHA proposes deleting this language because it is too vague and invites wide judicial interpretation. Hospitals and physicians routinely engage in contracts for the purposes of ensuring quality of care; these contracts are the only way to guarantee access to essential hospital services. These contracts already are subject to scrutiny under anti-trust statutes.