Concerns regarding economic credentialing/conflict of interest/self-referral

Level Playing Field Issues (in no particular order)
1) Contention: A hospital may determine that a physician has an economic conflict and deny privileges. But if that doctor is an independent practitioner and loses privileges at a hospital, he or she may lose malpractice insurance coverage and be unable to practice in that community without giving up participation in the conflicting entity. ***Advantage:*** Hospitals
2) Contention: A physician who has an economic conflict will send healthier/better insured patients to the facility in which he/she has the economic interest and less healthy/less insured (and perhaps more risky) patients to the hospital. ***Advantage:*** Physician and – depending on whether the infection rates are less and the cost is less -- the consumer (unless unexpected complications arise).
3) Contention: A physician in a clinic with auxiliary services, like laboratory, radiology, or physical therapy, can refer to those services and earn additional money from more referrals. In addition, economics may play a larger role in the referral than the patient's individual medical need for those services. A related issue is that insurers (e.g. Medicare) may pay more for the services of, for example, a physical therapist in a clinic setting than for an independent physical therapist. ***Advantage:*** Practitioner in clinic setting. Consumer benefits from ease of access. Not clear if better costs accrue to the consumer (depends on necessity of referral).
4) Contention: A hospital that hires hospitalists and employs physicians in private practice can streamline service by distinguishing between inpatient care and outpatient care and providing its employed physicians with malpractice insurance and economies of scale in purchasing, etc. ***Advantage:*** Hospital, hospitalists, and employed physicians.
5) Contention: The hospital that hires hospitalists and employs physicians in private practice can dictate practices based on economics (e.g. availability of types of medicines, prosthetics, lab services, etc.) and limit innovative medical practices. In best-case scenarios, the medical staff can exercise independent recommendations to balance economics with good medical practices. In worst-case scenarios, the economic interests of the hospital and a don't-rock-the-boat attitude of medical staff could result in imbalances between medical and economic values. ***Advantage:*** Hospital. Consumer may or may not be advantaged, depending on best-case or worst-case scenario.
6) Contention: The hospital and doctors are in a symbiotic relationship because only doctors can send a patient to a hospital. The issue here is that more hospitals are controlling the relationship by engaging in vertical integration, hiring doctors as employees for outpatients and other doctors as employees for inpatients. ***Advantage:*** Hospitals. ***Disadvantage:*** Independent practitioners
7) Contention: Competition by nonprofit and for-profit entities drives up the costs of health care as for-profit entities engage in self-referral, nonprofit entities expand their offerings to continue income streams, and all the entities have to pay for expensive medical equipment. ***Advantage:*** Potentially all providers. ***Disadvantage:*** Consumers and those paying for health care. (see #9, too)
8) Contention: Hospitals do not pay income taxes on their revenues, while for-profit providers do. There are few controls over the community benefits that are provided in exchange for income tax exemptions. ***Advantage:*** Hospitals. (See property tax issue below)
9) Contention: Hospitals provide charity care and write off uncompensated care as part of their community benefit. They generally cover more Medicaid, Medicare, publicly subsidized, and uninsured patients than do

for-profit providers. ***Advantage:*** For-profit providers.

10) Contention: Hospitals that exercise conflict of interest policies vis-à-vis independent physicians may grant privileges but may limit the availability of surgery suites and exercise other prerogatives that place independent physicians (and their patients) at a disadvantage. ***Advantage:*** Hospitals

11) Contention: ASCs/Outpatient surgery centers use hospitals as a backup, which complicates the scheduling of operating rooms at the hospitals, because the hospitals have to keep one surgery suite for emergencies, and if they get an emergency, then they have to open another surgery suite for an emergency, which bumps the scheduled surgeon/patient out of that room. ***Advantage:*** Physicians with specialty services in nonhospital settings. ***Disadvantage:*** Hospital and remaining medical staff.

Community Interest Issues

A) Contention: A vertically integrated system can streamline services, bring in physicians in specialties and primary care, provide greater health care coverage for a community, and allow for cross-subsidization of money-losing services such as emergency care. Also allows cross-subsidization to cover charity care cases. ***Disadvantage:*** In a worst-case scenario a hospital may implement rules and regulations that drive practitioners away, decreasing access to certain services in a community. Or a vertically integrated system may decide that services at particular satellite offices are uneconomic and close those offices.

B) Contention: Under the competition model, in which specialty hospitals or for-profit medical providers compete with non-profit providers, the specialty hospitals and for-profit medical providers are said to cherry-pick for the best insured or healthiest patients and usually focus on the most lucrative practices (cardiology and orthopedics), leaving the higher-cost and perhaps less-compensated services for the community hospital, which no longer can cross-subsidize as easily. This results in either the hospitals expanding into additional services or limiting/closing the uneconomic services. ***Disadvantage:*** Community hospitals that provide emergency care. Difficult to determine if consumer benefits from choice and more services being available – and that depends on whether the community hospital has to limit or close uneconomic services.

C) Contention: Nonprofit hospitals do not pay property taxes on their facilities while independent practitioners and for-profit facilities do. This includes not paying property taxes on primary care or outpatient practices if the nonprofit entity owns the building. ***Advantage:*** Non-profit health care facilities (defined in 50-5-101) licensed under the Department of Public Health and Human Services and organized under Title 35, chapter 2 or 3. (15-6-201, MCA)

D) Contention: Critical access hospitals typically have to provide various incentives (facilities, malpractice insurance, etc.) for practitioners to work in their area. They may be at a disadvantage in comparison to bigger communities.

Consumer Issues

i) Contention: Competition gives a consumer choice. ***Advantage:*** Depends on circumstances surrounding the choice – whether information is available to take advantage of the competition and whether the health care system is healthy enough to continue to offer a range of services.

Prepared by Pat Murdo, Legislative Services, based on SJR 15 and SB 417 testimony and conversations with proponents and opponents. 1/14/08