REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4, November 2020

Subject: Economic Discrimination in the Hospital Practice Setting (Resolution 718-A-19)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

At the 2019 Annual Meeting, the House of Delegates referred Resolution 718, "Economic Discrimination in the Hospital Practice Setting," which was introduced by the Organized Medical Staff Section. The Board of Trustees assigned this item to the Council on Medical Service for a report back at the 2020 Annual Meeting. Resolution 718 asked that our American Medical Association (AMA) actively oppose policies that limit a physician's access to hospital services based on the number of referrals made, the number of procedures performed, the use of any and all hospital services or employment affiliation.

This report addresses concerns regarding the use of case and volume metrics to limit access to hospital services by private practice physicians on hospital staff, summarizes relevant AMA policy, and makes policy recommendations.

BACKGROUND

Relationships between hospitals and physicians have changed over the years as health care payment and delivery systems have evolved, more care has moved to outpatient settings, and physician practice ownership has shifted away from physician-owned practice and toward working for a hospital or hospital-owned practice. The shift toward hospital employment is evidenced by AMA's Physician Practice Benchmark Surveys, which show that 35 percent of physicians worked either directly for a hospital or in a practice at least partially owned by a hospital in 2018, up from 29 percent in 2012.[1]

Hospital care has similarly evolved over time, such that inpatients are now sicker, hospital stays are shorter, and the hospitalist model—which was introduced in the 1990s—is in place in a majority of hospitals. Although primary care physicians and other generalist physicians still serve as inpatient attendings, far fewer specialists do so,[2] and most inpatient care is managed by hospitalists.[3] Prior to these shifts and the advent of hospital medicine, physicians largely practiced independently and managed patient care across outpatient and inpatient settings. Although many private practice physicians remain members of hospital medical staffs and have clinical privileges, most hospitals (approximately 75 percent in 2016) utilize hospitalists.[4]

Recently, concerns have been raised in the House of Delegates regarding hospital-physician relationships and hospitals giving preference to their employed physicians to the detriment of private practice physicians and patient-physician relationships. Referred Resolution 718-A-19 focuses specifically on concerns regarding hospitals using case and volume metrics to limit access to hospital services by private practice physicians who are on staff. The *AMA Physician's Guide to Medical Staff Organization Bylaws* speaks to similar concerns:

> In exclusive contracting situations, some hospitals argue that exclusive rights to use hospital resources, such as radiology equipment or operating rooms, can be awarded by contract to some holders of privileges, while others with the same privileges are barred from their use.[5]

Such actions by hospitals violate the intent of Policy H-230.982, which states that clinical privileges shall include access to those hospital resources essential to the full exercise of such privileges. To address these concerns, the *AMA Physician's Guide to Medical Staff Organization Bylaws* includes the following sample bylaw regarding clinical privileges:

> Clinical privileges or privileges means the permission granted to medical staff members to provide patient care and includes unrestricted access to hospital resources (including equipment, facilities and hospital personnel) which are necessary to effectively exercise those privileges.[6]

The Guide consists of sample bylaw language on self-governance and other issues relevant to hospital-medical staff relationships. A seventh iteration of the Guide was being developed at the time this report was written.

Physicians need full access to hospital services in order to provide high quality care to their patients. Additionally, physicians must have access to hospital services to maintain medical staff memberships and privileges. Case in point is The Joint Commission's Ongoing Professional Practice Evaluation (OPPE) requirements, which are factored into decisions to maintain existing privileges. Data used for the OPPE process must include physician activities performed at the hospital where privileges have been requested.

RELEVANT AMA POLICY

In addition to defining clinical privileges and addressing access to hospital resources, Policy H-230.982 states that privileges can be abridged only upon recommendation of the medical staff for reasons related to professional competence, adherence to appropriate standards of medical care, health status, or other parameters agreed upon by the medical staff.

An extensive collection of AMA medical staff policy aims to protect the rights of physicians who are members of hospital medical staffs. Policy H-225.942 delineates medical staff member rights and responsibilities, including fundamental rights that apply to individual medical staff members regardless of employment, contractual, or independent status. Policy H-225.950 includes principles for physician employment; Policy H-225.957 outlines principles for strengthening the physician-hospital relationship; and Policy H-225.997 addresses physician-hospital relationships. Policy H-220.951 requests The Joint Commission to require that conditions for hospital medical staff membership be based only on the physician's professional training, experience, qualifications, and adherence to medical staff bylaws. Policy H-230.953 encourages The Joint Commission to support alternative processes to evaluate competence, for the purpose of credentialing, of physicians who do not meet the traditional minimum volume requirements needed to maintain credentials and privileges. Policy H-225.984 encourages hospital medical executive committees to regularly examine hospital/corporate bylaws, rules and regulations for any conflicts with the medical staff bylaws, rules and regulations or practices. Policy H-230.987 supports the concept that individual medical staff members who have been granted clinical privileges are entitled to full due process in any attempt to abridge those privileges by granting exclusive contracts by the hospital governing body.

The AMA also has extensive policy on economic credentialing and volume discrimination. Policies H-230.975 and H-230.976 strongly oppose economic credentialing, defined in policy as the use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for hospital medical staff membership or privileges. Policy H-230.971 asks the AMA to work with The Joint Commission to assure that criteria used in the credentialing process are directly related to the quality of patient care. Under Policy H-225.949, medical staffs are encouraged to develop medical staff membership categories for physicians who provide a low volume or no volume of clinical services in the hospital, and also encourages medical staffs and hospitals to engage community physicians, as appropriate, in medical staff and hospital activities.

Policy H-285.964 states that hospitalist programs should be developed consistent with AMA policy on medical staff bylaws and implemented with the formal approval of the organized medical staff, and that hospitals and other health care organizations should not compel physicians by contractual obligation to assign their patients to hospitalists. This policy also opposes any hospitalist model that disrupts patient/physician relationships or continuity of care and jeopardizes the integrity of inpatient privileges of attending physicians and physician consultants.

As a benefit of membership, the AMA provides assistance, such as information and advice (but not legal opinions or representation) to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other similar entities (Policy D-215.990).

DISCUSSION

Although the Council was unable to find more than anecdotal information regarding physicians being subjected to the discrimination discussed in referred Resolution 718-A-19, it agrees that new policy is needed. The Council also believes that economic discrimination may be based on the type, as well as number of referrals made. Accordingly, the Council recommends actively opposing policies that limit a physician's access to hospital services based on the number and type of referrals made, the number of procedures performed, the use of any and all hospital services or employment affiliation. Having heard broader concerns about fairness and the need to protect physicians serving on medical staffs, the Council also recommends new policy recognizing that physician onboarding, credentialing, and peer review should not be tied in a discriminatory manner to hospital employment status.

The Council acknowledges the strength of existing AMA medical staff policy and recommends reaffirmation of Policy H-230.982, which states that clinical privileges shall include access to those hospital resources essential to the full exercise of such privileges, and that privileges can be abridged only upon recommendation of the medical staff, for reasons related to professional competence, adherence to appropriate standards of medical care, health status, or other parameters agreed upon by the medical staff. To address the OPPE issue, the Council recommends reaffirmation of Policy H-230.953, which encourages The Joint Commission to support alternative processes to evaluate competence, for the purpose of credentialing, of physicians who do not meet the traditional minimum volume requirements needed to maintain credentials and privileges. Finally, the Council recommends reaffirmation of Policies H-230.975 and H-230.976, which strongly oppose economic credentialing.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 718-A-19, and the remainder of the report be filed.

1. That our American Medical Association (AMA) actively oppose policies that limit a physician's access to hospital services based on the number and type of referrals made, the number of procedures performed, the use of any and all hospital services or employment affiliation. (New HOD Policy)

2. That our AMA recognize that physician onboarding, credentialing and peer review should not be tied in a discriminatory manner to hospital employment status. (New HOD Policy)

3. That our AMA reaffirm Policy H-230.982, which states that clinical privileges shall include access to those hospital resources essential to the full exercise of such privileges, and that privileges can be abridged only upon recommendation of the medical staff, for reasons related to professional competence, adherence to appropriate standards of medical care, health status, or other parameters agreed upon by the medical staff. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-230.953, which encourages the Joint Commission to support alternative processes to evaluate competence, for the purpose of credentialing, of physicians who do not meet the traditional minimum volume requirements needed to maintain credentials and privileges. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-230.975, which strongly opposes economic credentialing and believes that physicians should attempt to assure provisions in hospital medical staff bylaws of an appropriate role of the medical staff in decisions to grant or maintain exclusive contracts. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-230.976, which opposes use of economic criteria not related to quality to determine a physician's qualification for the granting or renewal of medical staff membership or privileges. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1]Kane C. Updated data on physician practice arrangements: For the first time, fewer physicians are owners than employees. American Medical Association Policy Research Perspectives. 2019. Available online at: https://www.ama-assn.org/system/files/2019-07/prp-fewer-owners-benchmark-survey-2018.pdf.
[2] Wachter, RM. Zero to 50,000—The 20th anniversary of the hospitalist. The New England Journal of Medicine 375;11 September 2016.
[3] Stevens JP, Nyweide DJ et al. Comparison of hospital resource use and outcomes among hospitalists, primary care physicians, and other generalists. JAMA Internal Medicine. Vol. 177, No. 12: 1781-1787. Nov. 2017. Available online at: https://pubmed.ncbi.nlm.nih.gov/29131897-comparison-of-hospital-resource-use-and-outcomes-among-hospitalists-primary-care-physicians-and-other-generalists/.
[4] Wachter, RM. Zero to 50,000—The 20th anniversary of the hospitalist. The New England Journal of Medicine 375;11 September 2016.
[5] American Medical Association. Physician's guide to medical staff organization bylaws, Sixth Edition. Updated March 2017.
[6] Ibid.