ALL THE PROCESS THAT’S DUE:
Provider Contracting in the World of Fair Procedures

October 22, 2013

Mary Powers Antoine, Esq.
Tom Curtis, Esq.
Mitch Green, Esq.
Nossaman LLP
At-will contracting is no longer a legally viable term in agreements for physician services.

Any party of significant economic power contracting for physician services must have a Fair Hearing Procedures Policy as an adjunct to the contract. Without one, the contract is incomplete and the party is at risk.
The Right to Terminate At-Will

- We begin by acknowledging the fundamental principle of freedom of contract: employer and employee are free to agree to a contract terminable at will or subject to limitations. Their agreement will be enforced so long as it does not violate legal strictures external to the contract.

  *Foley v. Interactive Data Corp. (1988)*

  47 Cal.3d 654, 677
The Common Law Right of Fair Procedures

- The common law doctrine of fair procedure protects against arbitrary decisions by private organizations under certain circumstances … When the doctrine applies, private entities may not expel or exclude qualified persons without acting in a manner that is **substantively rational** and **procedurally fair**.

  161 Cal.App.4th 206
At the heart of the matter…

- The inquiry is “focused on the practical power of the entity in question to affect substantially an important economic interest.”
Originally unrelated to healthcare

- First applied in two 19th Century cases involving private associations, including an association of Swiss immigrants rights to funds.

- Cases involving social clubs, fraternal societies, and other mutual benefit societies also cited.

- 1944: California Supreme Court applies doctrine to prohibit union from excluding African-American workers from membership on the arbitrary basis of race; analogies to innkeepers and common carriers (bus lines) with duty to furnish services to all persons.
81 years later expands to healthcare

- 1969: orthodontist rejected for membership in professional orthodontist societies because of affiliation with dentists who were not society members.

- 1975: physician’s application for hospital privileges summarily rejected because it did not include letters of reference from active hospital staff members.

- 1977: hospital dismisses resident without explanation.
The “modern era”

- 2000: *Potvin v. Metropolitan Life Insurance Company*

- Physician sues private health insurer after “delistment” as a preferred provider.

- California Supreme Court treats the private insurance company as a quasi-public entity, extending fair procedures from the hospital setting to private insurers with sufficient economic power.

- Fair procedures apply if “the insurer possesses power so substantial that the removal significantly impairs the ability of an ordinary, competent physician to practice medicine or a medical specialty in a particular geographic area, thereby affecting an important, substantial economic interest.”
The distinction between fair procedure and due process rights is one of origin and not of the extent of protection afforded an individual; the essence of both rights is fairness. Adequate notice of charges and a reasonable opportunity to respond are basic to both sets of rights.
And the winner is...
Fair Procedures Trumps At-Will

- We therefore agree with *Potvin* that the “without cause” termination clause is *unenforceable* to the extent it purports to limit an otherwise existing right to fair procedure under the common law.

What does this mean to you?

- Does not impact adverse action based on “medical disciplinary cause” under Bus. & Prof. Code § 805.

- 2008: $1.13 million jury award in *Palm Medical Group, Inc. v. State Compensation Insurance Fund*; medical group claims admission into a preferred provider network denied in violation of right to fair procedures

- 2013: $3.8 million jury award in *Nordella v. Anthem Blue Cross*
The facts of Potvin

- The facts are important because they show that fair procedure rights apply to common and routine credentialing issues.

- The provider agreement expressly provided for termination without cause.

- “Delistment” was based on a policy allowing a maximum of two malpractice lawsuits.

- Physician had four; all predating the provider agreement and three of which had been abandoned by plaintiffs.
The facts of *Palm Medical*

- Medical group’s initial application for workers compensation PPN membership denied

- Health plan policy expressly stated PPN would limit the number of providers in a geographic area.

- Membership based on recommendation of independent local liaison panel familiar with applicant's expertise.

- Unexceptional and commonly applied membership criteria: no practice restrictions, sanctions or disciplinary history; verifiable five-year malpractice history and educational history meet generally acceptable standards; significant experience in treating workers' compensation injuries.
The takeaway

- Previously confidential credentialing decisions based on legitimate and reasonable factors, including business and economic considerations, are now subject to scrutiny in an adversarial proceeding the results of which are subject to review by a court.
What are you going to do about this?

- Adopt a fair hearing procedure immediately.
- Take credit on your next performance evaluation for saving the company $3 million.
Developing a Policy

POTVIN AND PALM ARE POTENTIALLY APPLICABLE TO ANY FORM OF HEALTH CARE PROVIDER NETWORK:

- HEALTH PLANS
- INSURERS
- IPAs
- ACOs
- FOUNDATIONS
- MEDICAL GROUPS
THE ENTITY CLAIMING THE RIGHT TO A FAIR PROCEDURE MAY BE AN INDIVIDUAL, OR A MEDICAL GROUP, OR ANY CORPORATE ENTITY
The right to fair procedure extends to a medical corporation as well as to an individual physician. [Fund’s] suggestion that it had no duty to afford fair procedure to Palm because Palm is a corporation rather than an individual physician is also based on an overly narrow reading of the relevant case law.

Developing a Policy

THE RIGHT TO A FAIR HEARING MAY APPLY NOT ONLY TO A TERMINATION OF A CONTRACT BUT ALSO THE DENIAL OF AN APPLICATION OR ANY OTHER FORM OF EXCLUSION
“Neither in Potvin nor in any other case has the court indicated that the fair procedure doctrine does not apply to the refusal to admit an individual to a group that impacts the public interest . . . .

[T]he doctrine applies where exclusion, in the case of the medical profession, significantly impairs the ability of an ordinary, competent physician to practice medicine . . . .”

Palm Med. Grp., Inc. (supra) at 216-217
Developing a Policy

MUST EVERY MEDICAL PROVIDER THAT IS DENIED ENTRY OR TERMINATED FROM AN ENTITY BE AFFORDED FAIR PROCEDURE?
As we have explained, the common law right to fair procedure does not apply to an insurer’s removal of a physician from its preferred provider list unless the insurer possesses power so substantial that the removal significantly impairs the ability of an ordinary, competent physician to practice medicine or a medical specialty in a particular geographic area, thereby affecting an important, substantial economic interest.

Developing a Policy

- The duty to comply with the common law right to fair procedure arises if the entity possessed sufficient market power that exclusion significantly impairs the practice of the applicant’s profession or affects a substantial economic interest.

Palm Med. Grp., Inc., (supra) at 219
Developing a Policy

“The inability to compete for patients in 16 to 31 percent of the market is not necessarily insignificant. To the contrary, Palm’s evidence supports the conclusion that (Fund’s) share of the market was such that Palm’s inability to access patients covered by (Fund’s) policies . . . had a significant impact on its profitability.”

_Palm Med. Grp. Inc., (supra) at 220_
“Five percent of all insured in California participate in plans administered by United. (Eight percent of all PPO/POS insured do.) United is not an exclusive gatekeeper even as to these insureds. . . . United’s incomplete power to restrict access to 5% of all insureds is not so substantial that removal . . . would significantly impair the ability of our ordinary, competent physician . . . .
“[California Dermatology] argues that reduction of its patient volume by 60% and revenues by 50% indicates United possesses power so substantial . . . .”

“Any inquiry regarding . . . improvement must be an objective one.” [citing Potvin]

“A particular physician’s loss . . . does not prove . . . that removal . . . will generally . . . impair the ability to practice medicine. [citing Potvin]
THE IMPACT ON THE PROVIDER MUST BE SIGNIFICANT

THOUGH NOT SUFFICIENT ALONE, IT IS A NECESSARY ELEMENT TO ENTITLEMENT TO A HEARING
Developing a Policy

- Sound Appraisal v. Wells Fargo Bank 717 F.Supp.2d 940, 947 (N.D. Cal 2010); aff’d 451 F App’x 648 (9th Cr. 2011).

- “Plaintiffs’ has not alleged that removal from Defendants’ list of appraisals has, in any way, impacted their ability to reserve work from other mortgage companies. In fact, Plaintiffs’ allege that they do business with other “area mortgage brokers and major lenders.” [citing Potvin]
Establishing a Threshold

NO SINGLE THRESHOLD CAN ADDRESS EVERY SITUATION - SHIFT THE BURDEN TO THE PROVIDER
Establishing a Threshold

If the Plan intends to deny an application or terminate a Provider without stated cause pursuant to the terms of any agreement with the Provider, the Plan shall give the Provider a Notice of Review Rights at the same time the Plan gives the Provider notice of its intent to deny or terminate. The Notice of Review Rights shall advise the Provider of the right to request a review to challenge the action through submission of written statements, other documents, and other materials to the designated Plan Reviewer. The Notice of Review Rights shall include a copy of this Procedure.
Establishing a Threshold

If the Provider desires to exercise the review rights provided for in this Procedure, the Provider shall deliver to Plan a Notice of Request for Review within fifteen (15) days of the date of the Notice of Review Rights. At this same time, and as a requirement for exercising review rights, the Provider shall document its claim of potential significant impairment of ability to practice as a result of the proposed denial or termination. A Provider’s failure to timely deliver a Notice of Request for Review Date or documentation regarding significant impairment shall be a waiver of the Provider’s rights under this Procedure and deemed to be an acceptance by the Provider of the Plan’s action or proposed action.
Establishing a Threshold

Within fifteen (15) days after receipt from Provider of a Notice of Request for Review date, the Plan shall give the Provider notice if it rejects Provider’s showing of potential significant impairment, in which case all further review proceedings under this Procedure will terminate. However, the Plan may request specific additional information from the Provider, in which case the time for notice of a rejection will be extended to fifteen (15) days after receipt of the additional information.
What is Required?

- “[I]t is permissible for an association to initially reject an applicant without explanation, so long as the association clearly indicates to the applicant that, if he desires, the association will inform him of the reason for the rejection and will afford him an opportunity to respond.”

What is Required?

- *Pinsker II* demonstrated great flexibility in setting standards for admission fair procedures.

- “Associations themselves should retain the initial and primary responsibility for devising a method which provides an applicant adequate notice of the ‘charges’ against him and a reasonable opportunity to respond.” *Pinsker II* at 556.
What is Required?

IF THRESHOLD MET –

- GIVE NOTICE OF HEARING
- GIVE NOTICE OF REASONS FOR TERMINATION OR DENIAL
- GIVE NOTICE OF SELECTION OF DECISION MAKER -
  - VOIR DIRE?
  - ARBITRATION?
  - CSHA PANEL?
- GIVE NOTICE OF PROCEDURE -
  - HEARING?
  - BRIEFS?
  - ARGUMENTS?
What is Required?

- PLAN HAS BURDEN TO SHOW RATIONALITY
  - POTVIN
- PROVIDER HAS OPPORTUNITY TO RESPOND
- DECISION CAN BE FINAL WITHOUT INTERNAL APPEAL.

EXAMPLE:
What is Required?

If the Plan accepts the Provider’s showing of potential significant impairment, the Chief Medical Officer shall issue a Notice of Review Date and Proposed Action within fifteen (15) days after the Plan accepts the Provider’s showing of significant impairment. The Notice of Review Date and Proposed Action shall schedule a review date not more than ninety (90) days from the date on which the Notice of Review Date and Proposed Action is issued.
What is Required?

The Notice of Review Date and Proposed Action shall contain:

(i) the date of the review;

(ii) the proposed action against the Provider and the reasons for it and all written statements, briefs, exhibits, and declarations in support of the proposed action; and

(iii) notice of Provider’s right to submit written statements, briefs, exhibits and declarations to challenge the rationality of the proposed action. All such materials shall be submitted within 15 days of receipt of the Notice.
What is Required?

The Plan bears the burden of proving, by a preponderance of the evidence that the proposed action is neither arbitrary, capricious nor wholly lacking in evidentiary support.
What is Required?

- The Notice shall inform the Provider of the identities of the three persons appointed as the review panel, one of whom shall be designated as Chair. The panel members shall be appointed by the Chief Medical Officer and shall have not participated in the process of determining the proposed action nor shall they have any financial interest in the outcome of the review. Any objection that the Provider may have to any panel member must be on the basis of actual bias and must be submitted to the panel within three days of receipt of the notice. Objections will be ruled upon by the Chair.
What is Required?

- If a panel member must be removed or replaced, notice of the newly appointed member shall be given promptly and Provider shall have an additional 3 days to challenge the new member.
What is Required?

- The review panel shall review the submitted materials and render a written decision as to whether the Plan has met its burden to show the rationality of the proposed action. The decision shall state the reasons and evidence upon which it is based.
- The decision of the review panel shall be final.
It is the Process That Counts

- State Fund argued that Palm’s suit for damages was improper because Palm had not exhausted its administrative remedies.


- Court sustained $1.13 million jury award on basis that State Fund “had no formal administrative review process.”
Benefits of a Policy

BENEFITS:

- LESSEN THE NUMBER OF HEARINGS
- CREATE AN ADMINISTRATIVE REMEDY
- ESTABLISH A RECORD
- ESTABLISH THE BURDEN OF PROOF
- DEFINE THE PROCESS FOR FUTURE REVIEW
- LIMIT FUTURE CLAIMS
Looking Forward

- These claims are likely to become more prevalent as economic pressures increase (on both lawyers and doctors)
Looking Forward

- As new delivery networks are developed, more pressure to compete for fewer slots
  - QHP narrow networks
  - ACOs with exclusive or more lucrative contracts
  - Health systems establishing their own HMOs
  - Health plans consolidating or leaving the market
Credentialing decisions by health plans, medical groups and IPAs

- Now subject to these hearing obligations?
- Does this apply to applications as well as terminations?
  - Medical Groups/IPAs – YES
  - Health plans – YES
  - PPOs - YES
Provider Network Implications

- Is this leading to a *de facto* “any-willing-provider” obligation?
- What about freezing new enrollment?
- Will provider termination be used as a weapon to alleges retaliation for advocating for medically appropriate care in violation of whistleblower protections?
  - See Bus. & Prof. Code § 2056(c) (termination of contractual relationship)
- Waiver language in provider contract?
- Will termination w/o cause provision be enforceable?
  - *Potvin* held the contract provision purporting to deny the physician his common law right to fair procedure “is unenforceable to the extent it purports to limit an otherwise existing right to fair procedure under the common law.”
Protections

- Spell out criteria for inclusion in provider network in written policy
- Implement a policy for non-peer review hearings
- Educate provider network managers to be prepared to defend denial/termination decisions
- Routinely document reasons for denial or termination decisions
Protections

- Document a rational basis for the decision, e.g.,
  - Network is adequate
  - Failure to meet geographic location, specialty needs or other objective criteria
  - Failure to meet credentialing criteria (unrelated to quality, otherwise full peer review hearing required)
  - Member complaints unrelated to quality of care
  - Not based on bias, prejudice, discrimination
Questions?
NOSSAMAN LLP
Mary Powers Antoine
621 Capitol Mall, 25th Floor,
Sacramento, CA  95814
(916) 442-8888
mantoine@nossaman.com

Tom Curtis
18101 Von Karman Avenue, Suite 1800
Irvine, CA  92612
(949) 833-7800
tcurtis@nossaman.com

Mitch Green
50 California Street, 34th Floor
San Francisco, CA
(415) 398-3600
mgreen@nossaman.com