

**POST-ACUTE AND LONG-TERM CARE MEDICAL ASSOCIATION
WHITE PAPER
RESOLUTION A-13**

**SUBJECT: WHITE PAPER ON THE CORPORATE PRACTICE OF MEDICINE IN
LONG TERM CARE**

INTRODUCED BY: PUBLIC POLICY COMMITTEE

INTRODUCED IN: MARCH 2013

Introduction

In 2011, the PALTmed Public Policy Committee formed the Corporate Practice of Medicine (CPOM) Workgroup. The CPOM Workgroup was charged with a) reviewing and evaluating the concept of the CPOM Doctrine, b) investigating current state legislative actions seeking to remove restrictions on the CPOM in long-term care (LTC) settings, and c) formulating recommendations for further action. This paper summarizes the concept of the CPOM doctrine relative to LTC settings, discusses its relevance to healthcare in the twenty-first century, highlights recent state level actions, and presents the recommendations of the CPOM Workgroup.

Definitions

Most states have regulations prohibiting what is termed the CPOM. The CPOM has been defined in a number of ways (Bridgman Perkins 1998), but the essential feature of CPOM is that licensed healthcare providers are employed or managed by a lay corporation.

For this paper, we define the **CPOM** as it applies to LTC settings as:

An arrangement between a corporate entity and a healthcare provider, a healthcare provider practice, or a group of healthcare providers, in which a financial incentive exists for the care of patients in the long term care setting.

Such healthcare providers may be physicians, nurse practitioners, physician assistants, therapists, dentists, optometrists, or any other licensed healthcare professional.

Such an arrangement has the potential to influence medical decision making, possibly improving or hindering the care provided to residents. Because care can be influenced, potential conflicts of interest may arise.

The **CPOM Doctrine** is defined as:

A regulatory policy or position which prohibits the CPOM.

Background

The prohibition against the CPOM originated from actions of the American Medical Association (AMA) and individual states in the mid to late nineteenth century (Huberfeld 2004; Chase –Lubitz 1987; Chambers TD 1996). The CPOM Doctrine initially sought to protect the public from the commercial exploitation of healthcare by ensuring that physicians were not placed in a position where their loyalty

could be divided between their employer and their patients (Dowell 1994). To do this, all states established licensure qualifications that defined who could and could not practice medicine. Individuals could be licensed to practice medicine as long as they met the established criteria. Since corporations were not individuals, corporations could not be licensed to practice medicine. By extension, this meant that corporations could not employ or manage physicians as this would constitute the practice of medicine. In the twentieth century, the CPOM Doctrine was expanded to include all licensed healthcare providers, not just physicians (Chambers 1996; Wiorek J 1987). To this date, many states continue to have regulations supporting a CPOM Doctrine.

Analysis of the Relevance of the CPOM Doctrine Today

The CPOM Doctrine's origins came at a time when physicians worked independently and when the US healthcare system was in its infancy. Physicians were considered solo experts and drove decision making autonomously. Teams were not part of the healthcare fabric (Morrison 2010). The twentieth century witnessed great improvements in healthcare. Along with this though was a rise in healthcare costs and persistent disparities in access. As early as the 1920's, private and government efforts were launched to try and recreate healthcare by applying tested business principles in order to reduce healthcare costs, improve access, and enhance quality (Bridgman Perkins 1998). Such considerations of healthcare reform inevitably sought novel models of healthcare delivery that included corporate structures. These new corporate structures faced tremendous resistance and were challenged under the CPOM Doctrine. Examples of structures challenged under the CPOM Doctrine include Health Maintenance Organizations, free standing emergent care centers, corporate optometry practices, and hospitalist programs.

Today, it is clear that the US healthcare system has changed appreciably. We have new types of healthcare facilities, payment systems, and healthcare providers that could only have been imagined in the nineteenth century. Along with this growth, the culture of healthcare has changed. No longer is the physician the autonomous decision maker, but rather a collaborator in an interprofessional healthcare team characterized by shared accountability (Morrison 2010). Such culture change requires us to carefully re-evaluate the relevance of the CPOM Doctrine.

There are three central arguments traditionally posed to support the CPOM Doctrine (Huberfeld 2004; De Sa 1996 & Johnson 1995; Chase –Lubitz 1987):

- If healthcare providers are employed by corporations, their loyalty would be divided between their employer and their patients.
- Control over healthcare providers' clinical decisions by non-licensed individuals is likely to be inherently harmful.
- The possibility of commercial exploitation of healthcare providers is high given that corporations are not held to licensure standards.

PALMed recognizes that each of these arguments is inherently flawed. For example, independent providers working under a fee for service system can certainly be perversely incentivized to perform more services in order to increase their own revenue (Leibowitz 1996). Presence of corporate oversight is not necessary for this to occur. Likewise, corporate healthcare structures today must attend to a variety of voluntary and mandatory quality metrics for payment, regulatory, safety, as well as liability reasons. Corporate structures simply cannot ignore evidence-based care practices. Moreover a variety of regulatory oversights have been put into place to limit abuses such as self-referral, kickbacks, and abdication of liability. In fact, application of CPOM models is widely pursued today as an avenue for improvement in patient safety, quality of care, patient satisfaction, provider satisfaction, and in efforts to reduce unnecessary healthcare costs (Cutler 2009, Bohmer 2009, Bohmer 2007, Stevenson 2008).

Potential CPOM Conflicts Relevant to LTC

A number of changes are occurring in the field of LTC that could result in conflicts related to the CPOM. These include the movement towards closed medical staff models for physicians, direct employment of advanced healthcare practitioners, and the use of home-health and hospice organizations owned or operated by the facility. While the specific conflicts arising with each of these changes might be new, they are nonetheless conflicts occurring as a result of the influence of corporate employment. They are nothing more than variations on a theme. Importantly, AMDA recognizes that conflicts of interest will arise with any model of healthcare delivery in LTC and that no model has proven superior in preventing conflicts of interest.

Examples of potential conflicts of interest arising from recent changes in LTC include:

- 1) Use of Closed Medical Staff Models. Facilities have the obligation to establish a minimum set of criteria required for medical staff credentialing. These criteria should be reasonable expectations of the provider; should be congruent with the mission, quality of care and quality of life goals of the organization; and should be equally applied to all providers seeking to be credentialed at the facility. These expectations must be carefully followed by facilities directly employing providers.
- 2) Offering Resident Choice in Selecting a LTC Physician. Facilities have the right to establish a closed medical staff model. However, residents should have the right to choose their physician from the list of physicians available at the LTC facility. If a facility employs a physician or physician group, the facility should not preferentially refer patients to that physician or physician group. Facilities should disclose this relationship and inform patients of this potential conflict of interest. Patients being discharged from a hospital to a LTC setting should be given a choice of LTC facilities. Similarly, patients should also be made aware of all potential attending physicians available at their chosen LTC facility.
- 3) Certifying Need for Skilled Nursing Facility Services. Physicians and advanced healthcare providers employed by facilities should be free to determine the initial and ongoing need for skilled nursing facility services. Current CMS regulations address this for advanced healthcare practitioners but not for attending physicians (<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter04-08.pdf>)
- 4) Transparency in Use of Referral Services. While facilities may own or operate their own home health or hospice organizations, they should not place undue pressure upon physicians or advanced healthcare providers to utilize these specific services. In addition, they should disclose such relationships with residents. Likewise, a physician or advanced healthcare provider owning, operating or employed by a home health or hospice organization should disclose this relationship and avoid the pressures of self-referral.
- 5) Restrictive Covenants. Given the shortage of providers trained and dedicated to the practice of geriatrics and LTC, the use of restrictive covenants cannot be justified in this field. Allowing restrictive covenants dangerously monopolizes control of scarce resources and poses an imminent public health threat to the residents of the facility and community. Moreover, use of restrictive covenants seeks to limit patient choice in providers.

Recent Legislative Actions

Several states have recently introduced legislation that would abolish their CPOM Doctrines. In 2010, Colorado introduced legislation seeking to remove the restriction on the CPOM in LTC facilities. After lengthy investigation, the Colorado Medical Society ultimately decided to take no position on the bill. The bill was passed.

(http://www.leg.state.co.us/clics/clics2011a/csl.nsf/fsbillcont3/84ED90BB4A87FA0F87257818007C836F?open&file=084_enr.pdf)

Both Tennessee and Washington legislatures introduced bills seeking to lift the ban on CPOM specifically in nursing facilities. Tennessee Senate Bill 3263 (House Bill 3514) was ultimately passed, taking effect July 1, 2012. This bill removes restrictions on corporations from employing physicians provided that there is a written contract or job description containing language which does not restrict the physician from exercising independent medical judgment in diagnosing and treating patients. The bill states that the employing entity may not restrict or interfere with medically appropriate diagnostic or treatment decisions or referral patterns. In the event of any dispute, the burden of proof lies with the employer. (<http://legiscan.com/TN/text/SB3263/2011>)

Washington bill SHB 1315 was passed into legislation in 2011. Under this bill, nursing homes and related living facilities may employ physicians, again with the restriction the employer may not supplant, diminish, or regulate the physician's judgment directly or indirectly. The bill authorizes the DSHS to monitor nursing facilities employing physicians, reporting its findings to the legislature. (<http://apps.leg.wa.gov/documents/billdocs/2011-12/Pdf/Bill%20Reports/Senate/1315-S%20SBA%20HEA%2011.pdf>)

PALMed Recommendations

PALMed recognizes that conflicts of interest may arise regardless of the employment model for healthcare providers. It would be inappropriate for PALMed to support a CPOM Doctrine as proposed in the nineteenth century. Novel healthcare delivery systems exist today. Along with the presence of interprofessional teams sharing accountability and increasing regulatory and quality oversight, today's healthcare delivery systems have the potential to improve the safety and quality of healthcare while at the same time reducing healthcare costs, improving provider and resident satisfaction and access to care.

To ensure protection of the LTC resident as well as the healthcare provider, PALMed makes the following recommendations:

- 1) States enacting legislation to remove CPOM for LTC facilities prohibitions should include the following items:
 - a. The requirement for a written contract which stipulates language prohibiting the corporate entity from interfering, regulating, diminishing, or supplanting independent physician judgment. This includes, but is not limited, to the following items:
 - i. The determination for the need for skilled care services.
 - ii. Referral to other healthcare services including home health agencies and hospice organizations.

- b. Reiteration of the resident's right to be offered a choice of an attending physician that may not be employed by the corporate entity.
 - c. If a facility employs physicians or advanced healthcare practitioners directly or indirectly through an affiliated corporation, then the facility should disclose this relationship to new residents and the potential for a conflict of interest.
 - d. Physicians and advanced healthcare professionals practicing at the LTC facility must meet uniform specified written criteria for appointment to the facility. This would include those employed by the corporate entity as well as non-employed providers.
 - i. Credentialing criteria must be reasonable and pertinent to the mission and goals of the facility.
 - ii. Credentialing criteria must be evenly applied to all providers seeking privileges.
 - e. Given that healthcare providers specializing in geriatric medicine and LTC practice are a recognized minority force, facilities should not be allowed to require or include any form of restrictive covenant on employed physicians. Such practice could jeopardize adequate access to healthcare for LTC residents in the community, would reduce competition among providers, and foster the development of healthcare monopolies.
 - f. In the event of a dispute between the corporate employer and the employed healthcare professional, the burden of proof should lie with the corporate employer.
 - g. Appropriate penalties for corporate noncompliance with the regulation.
- 2) All residents being admitted to a LTC facility should be provided with a list of available attending physicians currently accepting new residents.
 - a. This list should identify which, if any, physicians are employed by the facility or an affiliated corporation.
 - b. The list should be provided prior to admission.
 - c. Residents should have the right to freely choose from among the physicians on this list.
 - 3) State Departments of Health should be required to monitor and report on the quality of care being provided by corporate entities in LTC settings.
 - 4) All LTC facilities monitor the quality and safety of care being provided by healthcare providers in their facilities, regardless of employment status.
 - 5) All LTC facilities monitor resident and provider satisfaction with care.

References

- Bohmer RMJ, Lee TH. The shifting mission of health care delivery organizations. *NEJM*. 2009;361:551-553.
- Bohmer R. The rise of in-store clinics: Threat or opportunity? *NEJM*. 2007;356:765-768.
- Bridgman Perkins B. Economic organization of medicine and the committee on the costs of medical care. *Am J Public Health*. 1998;88:1721-26.

Chase-Lubitz JF. The corporate practice of medicine doctrine: An anachronism in the modern health care industry. *Vanderbilt Law Review* 1987;40:445-488

Chambers TD. The corporate practice of medicine doctrine: A chimaera in the void? *Journal of the Medical Association of Georgia*. 1996;85:49-51.

Cutler DM. The next wave of corporate medicine: How we all might benefit. *NEJM*. 2009;362:546-551.

De Sa JM, Schrodel SP. Emerging State Policy Trends Related to Medical Group Practice: Alpha Center *J Amb Care Management* 1996.

Dowell MA. The corporate practice of medicine doctrine must go. *HealthSpan*. 1994;11(10):7-11.

Huberfeld N. Be not afraid of change: time to eliminate the corporate practice of medicine doctrine. *Health Matrix* 2004;14:243-291.

Jerrold L. The corporate practice of medicine. *Am J Orthodontics and Dentofacial Orthopedics* 2004;126:386-7.

Johnson BA. The legal issues of integrated delivery systems. *Medical Group Management Journal* 1995;17-22.

Leibowitz A, Hanchak NA, Schlackman N. Corporate managed care. *NEJM*. 1996;336:1060

Morrison G, Goldfarb S, Lanken PN. Team training of medical students in the 21st century: Would Flexner approve? *Acad Med*. 2010;85:254-259.

Stevenson DG, Grabowski D. Private equity investment and nursing home care: Is it a big deal? *Health Affairs*. 2008;27:1399-1408.

Wiorek J. The corporate practice of medicine doctrine: An outmoded theory in need of modification. *Journal of Legal Medicine*. 1987;8(3):465-484.

Workgroup Members

David Nace, MD, CMD, MPH (Chair)

Jabbar Fazeli, MD

Paul Slaughter, MD, CMD

Beata Skudlarska, MD, CMD

Leo Borrell, MD

Karyn Leible, MD, CMD

Jonathan Musher, MD, CMD

Eric Troyer, MD, CMD

Richard Lane, MD, CMD