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PRESIDENT'S MESSAGE

New Wrinkles

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There you are in your independent group. Doing everything right; well run; satisfaction scores high; all board certified docs; great relations with the administration, nursing, and the medical staff. Your group is well established; doesn't take a hospital subsidy.

The hospital has a hospitalist program, which has actually made your lives much easier when it comes to admitting patients. They are a good group and work well with your docs. They, however, do require a subsidy, a large one at that. Seems it costs the hospital seven figures to run the hospitalist program. Like most, your hospital is doing all that it can to stay in the black in these uncertain times.

One day, your CEO gets a call from a CMG. Usually he doesn't talk to them, as he is more than happy with your group and couldn't think of running the hospital without the ER group. Today, however, the call is a bit different. The CMG can add the seven figures that the hospital spends on the hospitalist service back to its bottom line. That's right, they will assume the hospitalist service at no cost to the hospital. In exchange, they also want the ED services contract. The two are bundled.

After much thought, the proposal goes before the board. The CMG promises that they will keep the same ER docs on, if they wish. The directors see that this will increase the net profit of the hospital, so they vote to accept the CMG's proposal. You and your group receive your 90-day notice. The CMG contacts you and sends you a contract replete with all the usual CMG clauses about which we have warned you. You can stay or move on to another hospital or community to start all over again. Through no fault of your own, you have been replaced.

This scenario is occurring throughout the country. You will note that many of the CMGs now also offer hospitalist services. By and large, that is not profitable, but it does provide access to an ED contract that may be **very** profitable. Of course, guess where the needed subsidy to pay the hospitalist comes from? You got it: the ED revenues. Fee splitting, anyone?

Another scenario comes to us from the West Coast. Your group is well established and has a similar profile to the one in our first example. Your contract comes up for renewal. The hospital wants to make a few changes this time. First, it wants you to increase your malpractice coverage limits from $1 million /$2 million to $2 million /$4 million. This will result in a substantial increase in your operating costs, thus a decrease in your income. Of course, the unintended consequence is that now you may very likely become a much more attractive target for the plaintiff attorneys. As if that is not enough, the hospital also includes an indemnity clause in your contract. This states that your group will pay any and all expenses involved if the hospital should be named as a co-defendant in a malpractice suit against one of the members of your group. Here you are on the hook for their legal fees as well as any settlement or judgment reached against them. Your liability is practically unlimited. You are not likely to find insurance for this. One group estimates that it would have to post a bond of $1 million in order to sign that contract. Obviously, no independent group could sign such a contract. On the other hand, a CMG could.

So, you ask, what can the Academy do about these new wrinkles? One action is to make you aware that these things are happening. We have begun reaching out to hospital administrators and educating them about the advantages of having a local, independent group staff their emergency departments. Depending upon how the practices are set up, a CMG using the ED physician revenues to subsidize the hospitalist contract could be fee splitting, which goes against Medicare laws.

In a situation like the second scenario, we will support groups that find themselves in this predicament. Enlisting the aid of state medical societies is something we have done. The Academy has a position statement against this type of clause. We are also looking into working with other

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cause of action for any person suffering personal harm as a direct result of a participating hospital's violation of a requirement. While a person is entitled to file a lawsuit against a hospital, the Court noted that under the principles of federalism, "state conditions simply cannot be recognized as conditions precedent to the vindication of a federally created right," in the "absence of a federal statute's express or implied acceptance of the state based condition for federal liability."

There are two sections of EMTALA that incorporate state law. The Court found, however, that neither section accepts CHH's proposed "state based condition for federal liability." The first section incorporates state law only as limitations on damages and does not incorporate procedural requirements for pursuing an EMTALA action. Thus, the Court determined that the section "does not, therefore, incorporate the MPLA screening certificate requirement."

In the second section, EMTALA provides that "only state and local laws that directly conflict with the requirements of EMTALA are preempted." CHH contended, "MPLA does not directly conflict with EMTALA, and, therefore, Plaintiff must comply with its [certificate of merit] requirements . . . Along with obtaining the certificate, West Virginia medical malpractice plaintiffs must, for example, file a notice of claim with all defendant providers, and obey specific time limits at various stages of bringing an action."

The Court disagreed with Defendant, holding instead that the West Virginia medical malpractice requirements "directly conflict with the EMTALA private right of action and are therefore preempted." As a controlling authority, the federal court drew on the Fourth Circuit's decision in "Power v. Arlington Hosp. Ass'n, 42 F.3d at 856, which . . . reasoned that the direct conflict arises because the timing requirements in state pre-suit procedures, and the time consumed in complying with those procedures, has an adverse effect on EMTALA's statute of limitations." Likewise, the federal court pointed out that West Virginia's MPLA contains specific waiting periods, such as "[a]t least thirty days prior to the filing of any medical professional liability action against a health care provider, the claimant shall serve . . . a notice of claim on each health care provider the claimant will join in litigation." But, even if it were to consider "only the screening certificate requirement, and not the wait period requirement (as Defendant appears to urge), the time involved in obtaining an expert and executing a certificate of merit under oath would also conflict with EMTALA through an adverse effect on EMTALA's statute of limitations . . . Thus, the MPLA pre-suit requirements at issue in this case are preempted because they directly conflict with EMTALA . . . [and] with Plaintiff's pursuit of his EMTALA action."

Another rationale for determining that the presuit procedural requirements are pre-empted was the Court's finding that the MPLA also "directly conflicts with Plaintiff's EMTALA disparate screening claim by imposing additional substantive conditions on his recovery. A physician providing a MPLA certificate of merit has to consider whether, and how, a plaintiff's medical care was below the applicable standard of care." The requirements for proving an EMTALA violation are different from those for proving a medical malpractice claim. The EMTALA screening cause of action is "not whether the screening met the applicable standard of care, but whether it was the same as that provided to other patients in the same facility." Cox's lawsuit is for a violation of EMTALA, and since the federal law does not require that a plaintiff file a "certificate of merit," the Court ruled that the "certificate of merit" requirements in the state malpractice statute were preempted when alleging an EMTALA violation. The Court denied the hospital its motion to dismiss.

The court's decision can be accessed at http://ia600809.us.archive.org/6/items/gov.uscourts.wvsd.76194/gov.uscourts.wvsd.76194.14.0.pdf

EMTALA case synopsis prepared by Terri L. Nally, Principal, KAR Associates, Inc.

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physician groups and specialty societies to advocate passage of laws forbidding such clauses. The AMA has been against this for some time and has a ready-made packet containing a suggested template for a bill outlawing such practices. Of course, the unintended consequence of the indemnity clause is that the hospital may get its "dirty laundry" aired in public. Once groups are placed in this position, it is easy to see how they might point the finger at the hospital, bringing up the fact that they were understaffed, failed to enact QI measures, etc. These clauses are negotiable, and we encourage any groups that find themselves up against them to negotiate those clauses out of their contracts.

I would like to thank Dr. David Vega for the fine job he has done as our editor for the last four years. He has worked tirelessly: keeping deadlines; tracking down authors to keep them on deadline; working with staff; and reading, reviewing, and editing every single article you read in each edition of *Common Sense.* He has raised the standard for this publication, and I look forward to working with him as a member of our board of directors.