

As Hospitals Trend Toward Employee Physicians, What Are the Employment Law Consequences?

By Josephine Vestal
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The recent increase in hospital-employed physicians is expected to continue. This trend is motivated by a quest for unified quality of care, referrals and market share, uncertainty about the overhaul of the healthcare system and reimbursement changes, and physician desire for a better work-life balance. Regardless of the reasons, transitioning from an independent

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contractor relationship with a physician to an employee physician has many consequences in the employment law arena.

The advent of this new norm - employee physicians - presents a change in the hospital's obligations to the physician beyond simply a motivating compensation model. The hospital now takes

on many obligations to the physician. It must provide employee benefits, unemployment compensation, workers' compensation, insurance and often retirement. The physician will receive the protection of employment laws such as the Americans with Disabilities Act (ADA) and the Family and Medical Leave Act (FMLA). Additionally, the discrimination and harassment provisions of Title VII, the Age Discrimination in Employment Act (ADEA), and the Fair Labor Standards Act (FLSA) apply. Please see > Hospitals, page 4

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Letter from the Publisher and Editor



Dear Reader,

We periodically update Healthcare News reader demographics on the advertising page of our web sites. Our May update showed 52,000 readers, 11,000 in Washington. Of the 52,000 Healthcare News readers, 27,000 are hospital employees. Other large categories include government and provider groups, with over 5,000 each. You can see our reader demographics at www.wahcnews.com.

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David Peel, Publisher and Editor

Washington Healthcare News 2012 Editorial Calendar

Month and Year	Theme of Edition	Space Reservation	Distribution Date
January 2012	Hospitals	December 1, 2011	December 26, 2011
February 2012	ASCs	January 3, 2012	January 30, 2012
March 2012	Hospitals	February 1, 2012	February 27, 2012
April 2012	Insurance	March 1, 2012	March 26, 2012
May 2012	Clinics	April 1, 2012	April 30, 2012
June 2012	Human Resources	May 1, 2012	May 28, 2012
July 2012	Hospitals	June 1, 2012	June 25, 2012
August 2012	Hospitals	July 2, 2012	July 30, 2012
September 2012	Clinics	August 1, 2012	August 27, 2012
October 2012	Human Resources	September 3, 2012	September 24, 2012
November 2012	Hospitals	October 1, 2012	October 29, 2012
December 2012	Clinics	November 1, 2012	November 26, 2012



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ployment Act (ADEA) and similar state laws impact the relationship in a new way. Also, the hospital may choose to bind the physician to a reasonable and enforceable noncompetition agreement.

In addition, the hospital-employed physician with medical staff privileges presents an intersection in the laws affecting peer review and human resources. This is especially true when there are complaints involving a physician's performance. Navigating the investigation of complaints or the termination of the physician's employment and denial of privileges can impact the peer review privilege as well as immunity provided by state law and the Health Care Quality Improvement Act (HCQIA).

In negotiating compensation, hos-

pitals should remember that there are many costs of having the employee that the employer did not have with the independent contractor. These include: professional liability insurance, employment taxes (such as the employer's share of social security), unemployment and workers' compensation taxes and all employee benefits (e.g. vacation, sick leave, life, health, and disability insurance and retirement plans). Additionally, an employee physician may have access to confidential proprietary information about the hospital and/or its employees that would not be available to a contract physician.

The hospital and prospective employee physician will want to negotiate an employment agreement that should consider duration of employment, circumstances under which the employee can be ter-

minated and, in addition to compensation, concomitant issues of hospital privilege, tail insurance, confidentiality, non-competes and non-solicitation of employees, patients, and referral sources, terms of payment, bonuses, benefits, practice control obligations to patients, moonlighting, practice development, arbitration and other ADR provisions. In considering compensation models, hospitals should keep in mind ethical obligations and patient safety, which are sometimes thought to conflict in alternative compensation models, such as volume-based.

Another area involves discrimination law coverage. While there is always an issue regarding whether discrimination laws apply to independent contractor physicians, there is no question that they apply to employee physicians. This

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means that employment decisions are easily challenged. Also, a plaintiff alleging discriminatory or harassing actions by an employee physician is in a better position to impose vicarious liability on the hospital than those making a claim against an independent contractor, where the standard is higher. Hospitals should consider providing harassment and discrimination awareness training specific to physicians, taking into account the unique circumstances among personnel in a hospital setting. Hospitals should also consider updating their discrimination and harass-

ment policies to clarify to whom an employee should report inappropriate conduct.

There is also protection for employee physician whistleblowers, as well as all other employees, under the Patient Protection and Affordable Care Act. This includes coverage for employees who report, or are about to report, violations of the Act to the employer or the government and employees who object to or refuse to participate in any activity that they reasonably believe violates the Act, among other things.

Beyond the prohibitions against discrimination and harassment, the hospital has affirmative obligations to the physician under the ADA and FMLA. The ADA requires that an employer provide a reasonable accommodation to a “qualified individual with a disability.” A disability is defined as a physical or mental impairment that substantially limits one or more major life activities, or a record of, or being regarded as having, such impairment. The 2008 amendments to the ADA broadened the

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scope of the definition of disability by expanding what qualifies as a major life activity to include most physical and mental functions.

To the extent that an employee physician has a disability, the hospital must use the interactive process to seek a reasonable accommodation that will allow the physician to effectively do his or

her job. In doing so, the hospital is in a unique position to take into account patient safety and quality of care concerns. Only if the hospital can identify a direct threat to patients, the disabled employee or coworkers, or if no accommodation is reasonable, can it decline to accommodate the employee.

The hospital must also consider the impact of complying with FMLA obligations to the employee physi-

cian. The employee physician may be entitled to take up to twelve weeks of leave each year for the birth or adoption of a child, his or her own serious health condition or to care for a family member with a serious health condition. There may also be ADA obligations to provide additional leave as part of a reasonable accommodation or additional pregnancy disability leave. Hospitals must consider the impact of the employee physician's eligibility for significant leave on its staffing models and be prepared to seamlessly provide healthcare through *locum tenens* or other arrangements while protecting the employee physician's leave and reinstatement rights.

Perhaps the most complicated area is when the investigation and decision-making functions of peer review committees and human resources departments collide. When it comes to an employee physician, the hospital's highly protected peer review information may well become fair game in litigation.

Allegations of employment discrimination under federal civil rights statutes, parallel state laws, claims of retaliation or wrongful termination most often rest upon indirect evidence, in which inferences of illegal actions may be drawn from witness testimony and related documents about the decision and the events leading up to it. For a hospital employee physician with staff privileges, the investigation and decision-making process is often conducted under the umbrella of highly confidential peer review. To prove the case, the physician will likely seek to compel the hospital to produce all



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documents related to the adverse decision and take the deposition of key decision makers. To protect its peer review material, the hospital will object adamantly (even if the information could help the hospital win its case). Whether the peer review privilege is fair game in the lawsuit depends in large part on whether the case is in federal or state court and what public policy issues are at play.

While most states have enacted statutory privileges restricting the release of medical peer review information, there is no corresponding federal privilege. Those state law privileges do not apply in federal court when a case is based on a federal anti-discrimination statute. Instead, federal courts will typically order the production of peer review records if there is any possibility that the documents may lead to information relevant to the claim. The number of employment-related claims where peer review information is sought through discovery is on the rise, often resulting in successful motions to compel. Courts will need to be educated on the health law ramifications of the production of peer review information, in order to limit production whenever possible.

It is vital to pay close attention during the investigation and decision-making process to the documents produced and the individuals involved. If a health care provider intends to claim the peer review privilege, it must be sure that all meetings involve only appropriate individuals, all relevant documents are marked as confidential peer review and the information is held confidential. For documenting in the personnel file, the employer

should consider simply including a general summary of the decision and note that the investigation was a confidential quality assurance/peer review matter.

The employee physician model has many advantages, and hospitals are wading through the employment law complications it presents. Paying close attention to these issues every step of the way can help avoid complications. Be

sure to contact a trusted legal advisor for assistance.

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Helping Health Care Payers Improve Claim-Payment Accuracy

By Paul Adams
*Director
Moss Adams LLP*



By Deanna Hodges
*Manager, Health Care Consulting Group
Moss Adams LLP*



The American Medical Association's fourth annual National Health Insurer Report Card found that commercial health insurers average a 19.3 percent error rate in processing claims, up 2 percent from the previous year. This increase means there were 3.6 million more erroneous payments and \$1.5 billion worth of additional, unnecessary administrative costs in the health care system. The AMA estimates that eliminating all errors would save more than \$17 billion overall.

Since the previous report, all examined health insurers but one

failed to improve their accuracy rating; United Health Care was the only commercial insurer to demonstrate an improvement. Claim-payment accuracy is a major concern for large commercial insurers, self-insured employers, independent physician associations (IPAs), and any organization that strives to accurately adjudicate health care claims. The big question, of course, is why these efficiency and accuracy levels are so troubling and potentially such a drag on the overall health care system.

The answer likely involves three

factors: people, processes, and technology.

In terms of people, many health care payers are deploying inexperienced claim examiners that will often err at a significantly high rate. Unfortunately, their training often falls short of what is necessary to ensure accurate and efficient payments, and many will continue making the same costly, repetitive payment errors once they become "experienced."

In terms of processes, a random audit is too often performed instead of a root-cause analysis. That's why a large number of errors aren't communicated to claims personnel in a comprehensive manner. The net outcome is that there's very little, if any, corrective action, so the same errors are repeated over and over again.

In terms of technology, payers continue to negotiate increasingly complex contracts and offer complicated benefit plans to members. Often, the contract terms and benefit provisions can't be fully automated in the claim-payment system. This creates a heavy reliance on manual processes, which inevitably leads to payment inaccuracies. Furthermore, these problems are exacerbated when critical claim-system support files are con-

figured and monitored by personnel with limited system or health care experience.

To address this problem, organizations will need to invest in staff and reengineer the processes that contribute to frequent payment errors. A six-point approach can help:

1. Upgrade training and audit programs. The training should focus on common mistakes, manual processes, and other key payment-error contributors.
2. Perform a root-cause analysis of common claim-payment errors. Communicate the results and collaborate with IT, contracting, and other departments to identify the best approach to reduce occurrences of each error type.
3. Encourage collaboration between audit and training teams. These departments should share information to help avoid common errors and train new claim examiners (and retrain existing examiners when necessary).
4. Review key claim-payment support files. Use experienced resources in claims, contracting, and IT to audit the configuration of claim-payment support files. This will help address the system-related root causes contributing to common payment errors.
5. Monitor common error occurrences daily. Once your organization completes training and implements redesigned processes, it's important to monitor the effectiveness of your efforts. Develop custom reports, filters, and other tools to provide daily

monitoring of the most common and costly errors.

6. Embrace health care reform. It's unclear exactly how the new law will be implemented, but your organization—like every other payer in the industry—will be judged on the accuracy and quality of outcomes and results; therefore, it's critical to make improvements in the coming years.

Whether your organization is a large commercial insurer, self-insured employer, IPA, or other type of health care claim payer, it's impossible to completely eliminate claim-payment errors. But the work of reducing errors should prove hugely beneficial: It will decrease claim expenses, boost revenue, en-

rich profits, and enhance the industry's reputation during one of the most complex transformations in modern health care history.

Paul Adams has more than 30 years of experience advising clients on revenue recovery, claim auditing, medical and hospital billing, managed care contracting, managed care operations, and information systems. He can be reached at Paul.Adams@mossadams.com.

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Medical Marijuana and the Workplace

By **Jim Shore**
Partner
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Legal issues involving medical marijuana continue to generate controversy, while posing complicated legal and philosophical questions for healthcare employers. State legislative efforts or voter initiatives (including a pending Washington State initiative) occur frequently around the country, backed by supporters seeking to regulate, legalize or decriminalize marijuana use and/or broaden medical marijuana users' workplace rights.

Washington is one of 17 states currently authorizing some form of medical marijuana use. However, with regard to workplace rights, last year the Washington Supreme Court ruled in *Roe v. TeleTech Customer Care Manage-*

ment that Washington's Medical Use of Marijuana Act ("MUMA") does not protect medical marijuana users from adverse hiring or disciplinary decisions based on an employer's drug testing policy.

Jane Roe (who used a pseudonym because medical marijuana use remains illegal under federal law) sued TeleTech for terminating her employment after she failed a drug test required by TeleTech's zero-tolerance substance abuse policy. She alleged that she had been wrongfully terminated in violation of public policy and MUMA because her marijuana use was "protected" by MUMA. The trial court granted summary judgment in TeleTech's favor, and Roe appealed all the way to the Supreme Court. The Supreme Court ruled 8-1 in TeleTech's favor, holding that MUMA provides an affirmative defense to state criminal prosecutions of qualified medical marijuana users, but "does not provide a private cause of action for discharge of an employee who uses medical marijuana, either expressly or impliedly, nor does MUMA create a clear public policy that would support a claim for wrongful discharge in violation of such a policy." The Court's holding applies regardless of whether the employee's marijuana use occurred while working or while off-site during non-work time. While

the *TeleTech* case did not involve a disability discrimination or reasonable accommodation claim under Washington's Law Against Discrimination, the Court did note that marijuana remains illegal under federal law regardless of what the State of Washington does, and that it would be incongruous "to allow an employee to engage in illegal activity" in the process of finding a public policy exception to the at-will employment doctrine. Moreover, the Court noted that the Washington State Human Rights Commission acknowledges that "it would not be a reasonable accommodation of a disability for an employer to violate federal law, or allow an employee to violate federal law, by employing a person who uses medical marijuana."

The Supreme Courts of California, Oregon and Montana have similarly ruled for employers, as has at least one federal trial court. But many unionized healthcare employers have collective bargaining agreements ("CBA") covering some or all of their employees. Depending on the circumstances (e.g., CBA language, past practice with analogous issues, principles of "just cause" discipline, and an arbitrator's tendencies), the *TeleTech* decision might be applied differently in a labor arbitration. Indeed, one Washington State arbitrator used "just cause" principles

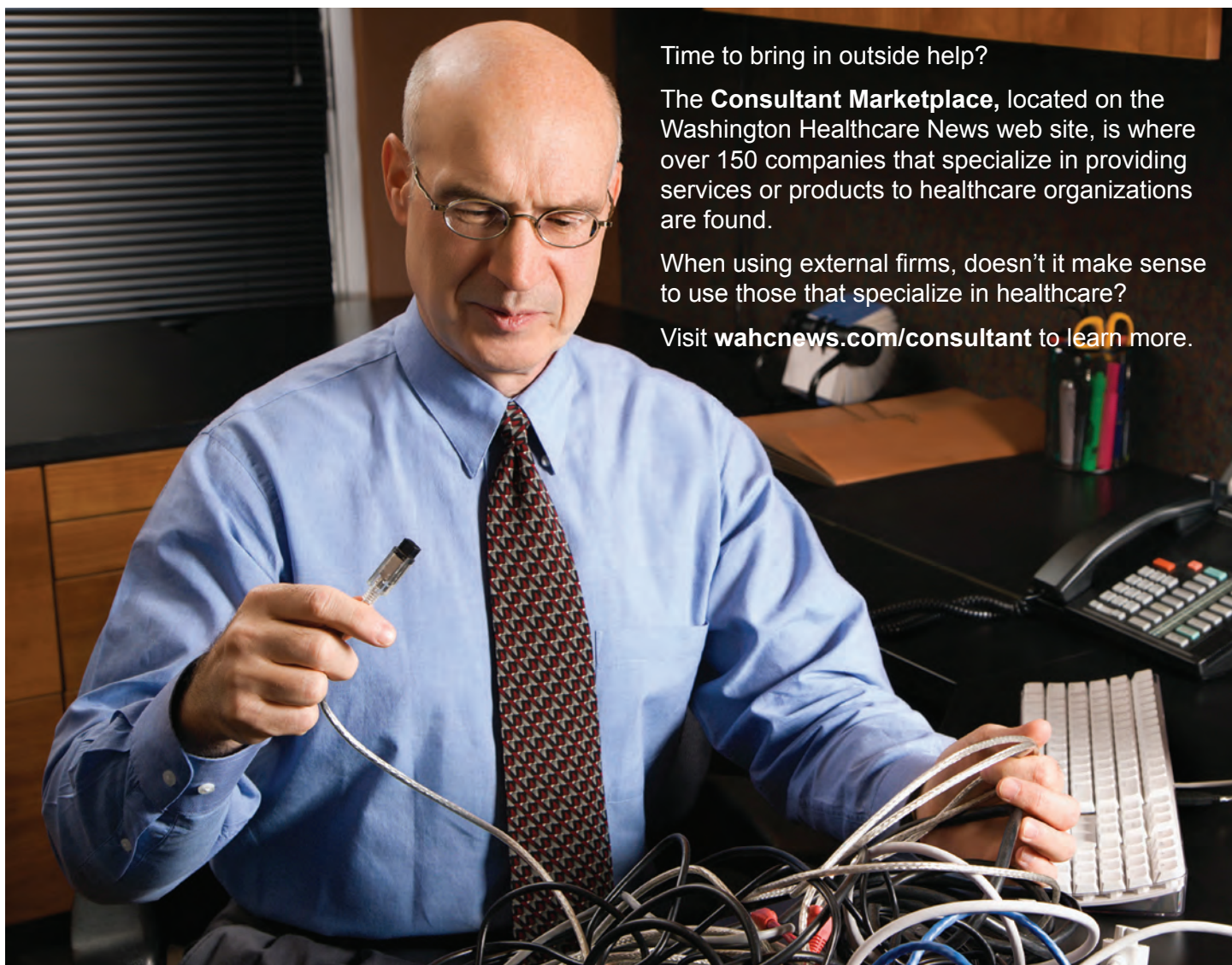
to overturn an employer's termination of a warehouse worker who failed a drug test due to medical marijuana use. Regardless, unionized employers can still take advantage of the *TeleTech* decision if they take certain steps and are consistent in their application of zero-tolerance drug testing policies.

Sound reasons exist for any healthcare employer to have zero-tolerance policies and a substance abuse testing program, such as quality patient care, government contracting requirements, federal or state laws, workplace safety, productivity, health and absenteeism, and third-party liability. Given the continued efforts by ad-

vocacy groups to "push the envelope" of medical marijuana laws into the workplace, it is important for healthcare human resource professionals to closely monitor legislative and legal developments. To best protect themselves, healthcare employers should review their existing policies to make sure that they comply with the law, and that they prohibit "any detectable amount" of drugs that are illegal under state or federal law, as opposed to merely prohibiting being "under the influence." Employers should also ensure that all human resources personnel and drug testing labs know how to handle medical marijuana issues as they arise. Healthcare providers that

authorize medical marijuana use for their patients should also weigh whether choosing to not make a medical marijuana exception to their drug testing policies will raise an institutional inconsistency. Particularly in a unionized workplace, this could give rise to an issue that might have emotional appeal to some arbitrators.

Jim Shore is a partner of Stoel Rives LLP, where he represents healthcare providers in all aspects of employment law and labor relations. Jim represented the employer in Roe v. TeleTech Customer Care Management. Contact Jim at jmshore@stoel.com or 206-386-7578.



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The Polyclinic Opens New Flagship Clinic at 7th and Madison

By Lloyd David
*Executive Director/CEO
The Polyclinic*



On May 14, The Polyclinic completes its move into our new flagship facility, The Polyclinic Madison Center. Located just off I-5, across from downtown Seattle, the building provides incredibly convenient access.

With nearly 200 health care providers, the Polyclinic has doubled in size over the past seven years. We have clinics located in North and South Seattle and near South Lake Union, but the largest concentration is on Seattle's First Hill, aka "Pill Hill." We outgrew our main facility on Broadway, near Swedish Medical Center and were forced to disperse clinics and administrative functions to nine different locations, resulting in oper-

ational inefficiencies and eroding the magic that comes from having so many services under one roof.

The overheated real estate and construction markets, combined with the scarcity of appropriately zoned land, made it extremely difficult to find an affordable facility solution. The real estate crash of 2008 provided the opportunity we needed. Partnering with an investment firm, we secured a beautiful new building shell and core, with 205,000 square feet, which had been built 'on spec' and had sat empty for two years (See top, page 13). The purchase price was literally half of what it cost to build, which allowed us to get a very reasonable lease rate. Combined with ending leases at several other buildings, it was a viable move for us financially. This also shaved at least two years off the development time frame and dramatically reduced the risk of the entitlements and construction process. It is the least costly and least risky facility solution that we could have found.

Ultimately, more than 120 physician practices and clinicians will relocate from their current First Hill locations to the contemporary nine-story building at the corner of 7th and Madison. The newly placed Polyclinic signs on the south and west side of the building can now be seen from the highway.

We are thrilled to have been able to lease this entire building for The Polyclinic because it allows us to return to our core goal of providing as many services as possible under one roof for the convenience of our patients, and to encourage collaboration between our physicians and other providers – something that's an integral part of our practice model.

Everyone benefits from this plan: We negotiated a fair long term lease, made aesthetic improvements to our corner with a well planned, beautifully landscaped underground garage following consultation with our neighbors, and are hoping to breathe a little more life into this area of First Hill which has faced some economic hardship in recent years.

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The Polyclinic Madison Center Building



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We designed The Madison Center with a combination of old values and new strategies. Physicians still have private offices, so they can call and e-mail patients in a private, confidential environment. We even think there may be a day when Skype type services exist. At 60 square feet, we felt this expense was worthwhile.

We abandoned a central check-in station, so patients could go directly to their physician's area. Blood draw stations are consolidated to minimize patient wait times. New lab equipment will enable patients to get their blood drawn, and then go to their appointment and review lab results

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Lloyd David is the Executive Director/CEO of The Polyclinic, a multi-specialty group located in and around Seattle. The Polyclinic has nearly 200 health care providers, including primary, specialty and surgical specialists, plus diagnostic imaging, laboratory, ambulatory surgery and other support services.

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