

# **1999 TEXAS HEALTH LAW CONFERENCE**

**November 11-12, 1999**

## **CREDENTIALING: NEW FRONTIERS? IRRECONCILABLE DIFFERENCES?**

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## **CREDENTIALING: NEW FRONTIERS? IRRECONCILABLE DIFFERENCES?**

### 1. ACCESS AND DUE PROCESS

- A. Medical Staff Members, Senate Bill 1132 (eff. 5/21/99), amending Hospital Licensing Law, Tex. Health & Safety Code Sec. 214.101(c).
  - 1. Extends the procedural due process requirement for applications to a hospital's medical staff to "renewal, modification, or revocation of medical staff membership and privileges."
  - 2. Emphasizes need to address status of continued clinical privileges for practitioners providing professional services pursuant to exclusive staffing contract. If intending to terminate privileges in exclusive area, should obtain signed waiver from each affected practitioner, waiving all procedural due process rights under the medical staff bylaws and by law in the event of (1) termination of the contract, or (2) termination of the practitioner's employment or other relationship with the contracting entity.
- 2. Advanced Practice Nurses (APNs) and Physician Assistants (PAs).
  - 1. Senate Bill 1131 (eff. 9/1/99), adding Sec. 241.105 to Tex. Health & Safety Code.<sup>1</sup>
    - 1. Hospital may but is not required to establish policies granting clinical privileges to APNs and PAs, including policies on the application process, reasonable qualifications and process for renewal, modification or revocation of privileges. Policies must:
      - (1) specify a reasonable time period for the processing and consideration of the application, and
      - (2) provide for written notification to the applicant of final action on an application, including any reason for denial or restriction of requested privileges.
    - 2. Hospital that modifies or revokes privileges must provide "certain procedural rights to provide fairness of process, as determined by the hospital's governing body." At a minimum, rights will include:

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<sup>1</sup>SB 1131 also added APNs and PAs to the choice of practitioner clause in Tex. Ins. Code Art. 21.52, but allows for different payment or reimbursement for their services as long as same reimbursement methodology used to calculate payment when services provided by a physician.

- (1) Written reasons for modification or revocation of privileges, and
  - (2) A mechanism for appeal to the appropriate committee or body within the hospital.
3. If the APN or PA is required to have a sponsoring or collaborating relationship with a physician and that relationship ends, the APN or PA and the physician must notify the hospital. Once the hospital received notice from the APN or PA and physician, the hospital is deemed to have met its fairness of process obligations by giving the APN or PA written notice of termination of the privileges.
  4. Section does not modify scope of practice or apply to an employer-employee relationship between the APN or PA and the hospital.
  5. Issues:
    - (1) Can hospital use clinical privileges for all allied health professionals except APNs and PAs, using a task description for them?
    - (2) Can hospital afford an “appeal” to APNs and PAs with clinical privileges, but something different for all other allied health professionals with clinical privileges?
    - (3) If an APN’s clinical privileges are terminated due to failure to care adequately for a patient or unprofessional conduct, must the matter be reported to the Board of Nurse Examiners (BNE) and subjected to nursing peer review under Tex. Rev. Civ. Stat. Ann. art. 4525a, Sec. 2?
    - (4) Can those APNs employed by the hospital be reported to the BNE and subject to the nursing peer review process while non-employed APNs are not?
    - (5) Can the “appeal” process for APNs be nursing peer review?
2. JCAHO Standards for Hospitals (1999)
    1. MS.5.14: All individuals who are permitted by law and by the hospital to provide patient care services independently in the hospital have delineated clinical privileges, whether or not they are

medical staff members.

- b. MS.5.2: There are mechanisms, including a fair hearing and appeal process, for addressing adverse decisions for existing medical staff members and other individuals holding clinical privileges for renewal, revocation, or revision of clinical privileges. MS.5.2.1: These mechanisms may differ for medical staff members and other individuals holding clinical privileges.
3. Access to Managed Care.
    1. *Tex. Ins. Code Art. 20A.14(i) and Art. 3.70-3C, Sec. 2, require that HMOs and insurer-sponsored preferred provider benefit plans accept a participating physician's request to have his/her PAs and APNs identified as providers in the network unless the PA or APN fails to meet the quality of care standards for their participation. HMOs and preferred provider benefit plans may not refuse to contract with or reimburse PAs and APNs for covered services or otherwise discriminate solely because they are not listed in the right to select practitioner provisions of Art. 21.52.*
    2. *Texas Department of Insurance (TDI) Regulations for HMOs, 25 TAC Sec. 11.1902, require credentialing of all physicians, providers permitted to practice independently, and APNs and PAs.*

## **II. ANESTHESIA**

1. Outpatient Settings, Senate Bill 1340 (eff. 9/1/99), amending Medical Practice Act, Tex. Rev. Civ. Stat. Ann. art. 4495b by adding Subchapter G, and adding Art. 4527e to Nursing Practice Act, Tex. Rev. Civ. Stat. Ann. Art. 4513 et seq.<sup>2</sup>
  1. *Requires both Board of Medical Examiners (BME) and BNE to adopt rules establishing minimum standards for the provision of anesthesia services in any "outpatient setting" or facility, clinic, center, office, or other setting that is not part of a licensed hospital or licensed ambulatory surgical center. Exceptions for setting where type of anesthesia limited, operated by government, or accredited by Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Association for the Accreditation of Ambulatory Surgery Centers, or Accreditation Association for Ambulatory Health Care.*

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<sup>2</sup>See new codification in Texas Occupations Code.  
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2. The boards are authorized to conduct inspections to enforce the rules. The boards may also inspect at a licensee's request and issue an advisory opinion. Board is not bound by advisory opinion, but may consider licensee's reliance on the opinion as mitigating evidence in administrative or civil penalty proceeding.
  3. Effective August 31, 2000, physicians administering anesthesia or performing a surgical procedure for which anesthesia services are provided in an outpatient setting and certified registered nurse anesthetist (CRNA) providing anesthesia in an outpatient setting must comply with their respective board's rules. They may also be required to submit corrective action plans to remedy or address any deficiencies.
  4. Effective September 1, 2000, physicians subject to the rules must register with the BME annually and CRNAs with the BNE biennially.
2. CRNAs and Supervision, Texas Attorney General Opinion JC-0117 (Sept. 28, 1999).
    1. Requested by BNE, opinion provides that BNE has authority to regulate the selection and administration of anesthesia and the care of an anesthetized patient by a CRNA. A physician who delegates the selection or administration of anesthesia to a CRNA may but is not required to directly supervise the CRNA.
    2. The extent of physician involvement is left to the physician's professional judgment in light of other relevant federal and state laws, facility policies, medical staff bylaws, and ethical standards (referencing Medicare conditions of participation requiring supervision, state controlled substances law requiring agent to administer controlled substance in presence of physician).
    3. Issue: Is there a difference between "supervision" and "direct supervision"? Will this affect the supervision required by the Medicare conditions of participation?

### **III. PRIVILEGES OF CONFIDENTIALITY**

1. Public Hospitals, Hospital Districts and Hospital Authorities.
  1. Open Meetings Act, Tex. Gov't Code Ann. Sec. 551.002. Provides that every regular, special or called meeting of a governmental body shall be open to the public, unless excepted in the statute. There is an exception for personnel matters, however, the court in Swate v. Medina Community

Hospital, 966 S.W.2d 693 (Tex. App.---San Antonio 1998, writ denied), held that “a governmental body violates the Texas Open Meetings Act if it meets in executive session to discuss any employment matter involving an independent contractor.”

2. House Bill 2171 (eff. 6/19/99), amending Medical Practice Act, Sec. 1.03(a)(5), adding Section 5.06(v), amending Tex. Health & Safety Code Sec. 161.031(a), 161.032(a) and (c), and adding Sec. 161.0315.
  1. Amends Medical Practice Act to specifically include a hospital district and hospital authority in the definition of “health care entity” at Sec. 1.03(a)(5).
  2. Amends the medical committee privilege at Tex. Health & Safety Code Sec. 161.031(a) to add hospital district and hospital authority to the definition of a “medical committee.”
  3. Amends Tex. Health & Safety Code Sec. 161.032(a) dealing with confidentiality, to provide that a proceeding of a medical peer review committee, medical committee or governing body of a public hospital, hospital district or hospital authority at which the governing body receives records, information or reports provided by a medical committee or medical peer review committee is not subject to Chapter 551 of the Government Code or the Open Meetings Act. Also provides that records, information or reports of a medical committee or medical peer review committee and records, information or reports provided by the committee to the governing body of a public hospital, hospital district or hospital authority are not subject to disclosure under Chapter 552 or the Open Records Act.
  4. Adds a new Section 161.0315 authorizing governing bodies to form medical peer review committees and medical committees to evaluate medical and health care services.
  5. Provides that committees of hospital districts may not evaluate those services provided by a health care facility that contracts with the district to provide those services and has formed a medical peer review committee or medical committee to evaluate the services provided by the facility.
  - f. Allows a hospital district to require by contract with a health care facility that the district’s governing body may appoint members to the facility’s committee and that the governing body may receive

reports from the committee in closed session (additional provisions if the parties cannot agree to a contract provision).

3. House Bill 747 (eff. 6/19/99), amending Sec. 1.03(a)(6) of Medical Practice Act. The term “medical peer review committee” or “professional review body” includes the governing body of a public hospital, hospital authority and hospital district, but only:
  1. In relation to the governing body’s evaluation of the competence of a physician or the quality of medical or health care services provided by the hospital, authority or district; and
  2. To the extent that the evaluation referenced above involves discussions or records that specifically or necessarily identify an individual patient or physician.
4. Texas Attorney General Opinion JC-0108 (Sept. 9, 1999). Interprets the amendments by House Bills 2171 and 747 together. Provides that action by the governing body that is not subject to the Open Meetings Act is exempt from all requirements of the Act, including notice and the requirement that the final action, decision or vote be in an open meeting.
5. Issues: Is there any privilege of confidentiality for credentialing or peer review of non-physicians?
2. Health-care Entity, House Bill 2171(see Section A above). Also amended the definition of health-care entity that “pays” for medical or health-care services and follows a formal peer review process. Sec. 4 amending Medical Practice Act, Sec. 1.03(a)(5)(B).
3. Texas Department of Health (TDH) Records, House Bill 2824 (eff. 8/30/99), amending Sec. 241.051 of Tex. Health & Safety Code (among other things).
  1. All information and materials obtained or compiled by TDH in connection with a complaint and investigation of a hospital are confidential and not subject to subpoena under Sec. 552.001 (Open Records Act) or subject to disclosure, discovery, subpoena, or other means of legal compulsion for release to anyone other than TDH or its employees or agents involved in the enforcement action.
  2. Information may be disclosed to:
    1. Persons involved with TDH on the enforcement action;

2. The hospital that is the subject of the action or its authorized representative;
  3. Appropriate state or federal agencies authorized to inspect, survey or investigate hospital services;
  4. Law enforcement agencies; and
  5. Persons engaged in bona fide research if all individual-identifying and hospital-identifying information has been deleted.
3. The following information is subject to disclosure under Sec. 552.001 et seq.:
    1. Notice of alleged violation against the hospital, which notice shall include the provisions of law that the hospital is alleged to have violated and a general statement of the nature of the alleged violation;
    2. Pleadings in the administrative proceeding; and
    3. A final decision or order by TDH.
  4. Similar provisions under Sec. 577.013 for psychiatric hospitals.

#### **IV. BOARD OF MEDICAL EXAMINERS' CREDENTIALS COLLECTION PROGRAM**

- A. House Bill 3216 (eff. 9/1/99), adding Subchapter G to the Medical Practice Act, establishing a mandatory credentials collection program to be implemented not later than September 1, 2001. A physician whose "core credentials data" is submitted to the BME is not required to resubmit the data when applying for practice privileges with a health care entity and the health care entity must use the BME for that data provided the BME is designated or accepted as primary source by a national accreditation organization.
  1. "Core credentials data" is name and other demographic data, professional education, professional training, licenses and ECFMG certification.
  2. "Health care entity" means a facility or organization licensed or certified to provide medical and allied health services in the state, a Texas licensed prepaid health plan or HMO, an insurer providing health care through a

network of providers, or a provider entity accepting delegated credentialing functions from a HMO. Health care entities that employ, contract with or credential physicians must use the BME data. A health care entity may act through its designated CVO.

3. Physician must provide any correction, update or modification to core credentials data to BME within 30 days from the date the information on file is no longer accurate, and resubmit annually if no correction, update or modification submitted within preceding year.
  4. BME must furnish data to health care entity within 15 days of request. Before releasing for the first time, the BME must give the physician 15 days to review and request reconsideration/resolution of errors or omissions.
  5. Health care entity and its CVO is immune from liability arising from reliance on BME's data. Information is confidential and not subject to discovery or subpoena except as provided in the statute.
  6. BME may use an independent contractor and charge fees necessary to cover cost of operation and administration. BME may use gifts, grants and donations to fund. BME may implement the bill only if the Legislature appropriates money for that purpose. If none allocated (and none were), it may only implement using other appropriations, gifts, grants or donations available for that purpose.
2. Physician profiles, House Bill 110 (eff. 9/1/99), adding Sec. 5.12 to the Medical Practice Act. Physician profiles to be made available by BME by September 1, 2001. Profile will include hospitals at which physician practicing, convictions for felonies and certain misdemeanors, description of charges to which the physician has pleaded no contest or received deferred adjudication, description of BME or other state disciplinary actions, and description and status of formal complaints with BME.
  3. Licensure Grace Period, Senate Bill 1207 (eff. 8/30/99), amending Sec. 3.01 of Medical Practice Act (among other sections). Provides for a 30-day grace period from the date of expiration of the physician's existing annual registration permit.

## **V. DELEGATED CREDENTIALING**

### **A. Legal Requirements.**

1. *HMOs, 28 TAC Sec. 11.1902(5)(viii).*

- a. *If the HMO delegates the credentialing function, it must have written procedures for the delegation which include criteria for delegation, pre-delegation audit procedure and criteria, delegation agreement, monitoring plan, and a procedure for termination of the delegation agreement for non-performance.*
  - b. *Documentation of pre-delegation evaluations performed, executed delegation agreements, reports received from delegated entities, current rosters or copies of signed contracts of physicians and providers affected by the delegation agreement, and continuing monitoring evaluations shall be maintained by the HMO and made available to TDI for review. Credentialing files at the delegated entity must be made available to TDI upon request.*
2. *Senate Bill 890, eff. 9/1/99 (Sec. 3 of legislation on description of plan terms eff. for contracts on or after 1/1/2000), adding subsections (dd) and (ee) to Tex. Ins. Code Art. 20A.02. A HMO that enters into a delegation agreement with a “delegated network” shall have a written agreement, filed with TDI not later than the 30th day after executed. “Delegated network” is defined as an entity other than a HMO or insurer that (i) itself or through one or more entities undertakes to arrange for or provide medical care to an enrollee in exchange for a predetermined payment on a prospective basis; and (2) performs on behalf of the HMO any function regulated by the HMO Act. The agreement must contain:*
- a. *A monitoring plan which includes:*
    - (1) *Description of financial practices that will ensure that the delegated network tracks and reports liabilities that have been incurred but not reported,*
    - (2) *Summary of total amount paid by the delegated network to physicians and providers on a monthly basis, and*
    - (3) *Summary of complaints from physicians, enrollees, and providers regarding delays in payment of claims or non-payment of claims, including the status of each complaint, on a monthly basis;*
  - b. *A provision that the agreement cannot be terminated without*

*cause by the delegated network or the HMO without 90 days prior written notice;*

- c. A provision that prohibits the delegated network and its contracting physicians and providers from billing or attempting to collect from any enrollee under any circumstance, including insolvency of the HMO or network, payments for covered services other than authorized copayments/deductibles;*
- d. A provision that the delegation agreement may not be construed to limit in any way the HMO's authority or responsibility, including financial responsibility, to comply with statutory and regulatory requirements;*
- e. A provision that requires the delegated network to comply with all statutory and regulatory requirements related to any function, duty, responsibility, or delegation assumed by or carried out by the delegated network;*
- f. A provision that requires the delegated network or third party to provide a license number and certify licensure as a third party administrator if the HMO delegates its claims payment function;*
- g. A provision that requires the delegated network or third party to provide a license number and certify licensure as an utilization review agent if the HMO delegates its utilization review function and attest to compliance with certain requirements;*
- h. Acknowledgment and agreement by the delegated network that the HMO is required to operate and maintain a provider credentialing system and quality assurance system, is directly accountable for those systems, and may cancel any or all delegation if the network fails to comply with statutory and regulatory requirements;*
- i. A provision that the network provide the HMO with data necessary for the HMO to comply with TDI reporting requirements with respect to any delegated function; and*
- j. A provision requiring the network to report enrollee complaints to the HMO within two (2) business days (or*

*immediately in the case of emergency care).*

*The legislation also sets out required information that the HMO must provide to the delegated network, required procedures if the HMO receives information through the monitoring plan that the network is not operating in accordance with the agreement or in a manner that renders continuance of the business hazardous to enrollees, provides for procedures to correct deficiencies, and requires notice by the HMO to TDI and an intervention request in certain situations.*

**B. Accreditation Standards.**

1. JCAHO Standards for Health Care Networks (JCAHO/Networks) (1998-2000).
  - a. No specific provisions on delegated credentialing.
  - b. LD.3 *When the network contracts for or delegates any function(s) or process(es) addressed by standards in the manual, the network: (i) uses clear criteria and performance expectations to select contractors/ delegates; (ii) actively oversees contracted (that is, delegated) activity(ies) using clear criteria and performance expectations; (iii) periodically corroborates with the contractor/delegate to coordinate activities; and (iv) retains the right to make key decisions. The network also maintains evidence that the contractor/delegate complies with applicable standards in the manual.*
  - c. HR.3 *All individuals permitted by law and by the network to practice independently in the network are appointed or reappointed to the network's practitioner panel through a defined process(es).*

Footnote to HR.3: *A network may determine to use and not to duplicate the credentialing process and appointment or reappointment decision of a component that the network itself has determined meets the standards in this chapter, or of a hospital component that is accredited by JCAHO. In both these circumstances, the network still must comply with the requirement of HR. 3.16, HR. 3.16.1, HR. 3.19, and HR.3.19.1 (dealing with the network's required evaluation of clinical records and office practices of practitioners and the use of predetermined measures appropriate to care delivered*

at each practitioner site to make its evaluation).

2. *National Committee for Quality Assurance (NCQA) Standards for Accreditation of Managed Care Organizations (NCQA/MCOs)(1999)---CR 13.*
  - a. *If the MCO delegates any credentialing and recredentialing activities, there is evidence of oversight of the delegated activity. A mutually agreed upon document describes: (i) the responsibilities of the MCO and delegated agency; (ii) the delegated activities; (iii) the process by which the MCO evaluates the delegated agency's performance; and (iv) remedies, including revocation of the delegation, if the delegated agency does not fulfill its obligations.*
  - b. *The MCO retains the right, based on quality issues, to approve new practitioners, providers and sites, and to terminate or suspend individual practitioners or providers. There is evidence that the MCO evaluates the delegated agency's capacity to perform prior to delegation, and evaluates annually whether the delegated activities are in accord with the MCO's expectations and NCQA standards.*
3. *NCQA Standards for Certification of Physician Organizations (1999)---CR 13 (same standards as for NCQA/MCOs above).*

**C. Legal Issues.**

1. *Confidentiality. Delegation should be structured to maintain available privileges of confidentiality as to information generated, disclosed or exchanged between MCO or health care delivery system and delegated entity.*
  - a. *Patient Information.*
    - (1) *NCQA/MCOs QI 3.0 Health Services Contracting. Requirements to participate in QI activities are incorporated into all practitioner/provider contracts. Contracts specify that practitioner/providers will allow the MCO access to the medical records of their members to the extent permitted by state law.*
    - (2) *Delegation will need to address requirements under state law (and federal law if dealing with substance*

*abuse records - 42 C.F.R. Pt. 2) to allow MCO or health care delivery system and delegated entity access to patient records and information.*

- (3) *Delegated entity needs to be bound by same confidentiality limitations and obligations as are imposed on MCO or health care delivery system. Authorizations from patients should be drafted to extend to delegated entities or agents.*

*b. Peer Review Information.*

- (1) *The MCO or health care delivery system (delegating entity) will be generating its own peer review information and may request peer review information from contracting practitioners, whether individuals, practice groups or institutions.*
- (2) *The scope and application of state laws protecting peer review information should be reviewed to determine if information generated by the delegating entity in the process of credentialing will be protected as confidential, and if sharing of information will jeopardize any available privileges of confidentiality. See *McClellan v. HMO of Pennsylvania*, 604 A.2d 1053 (Pa. Sup. Ct. 1992), appeal denied, 616 A.2d 985 (Pa. 1992): IPA-model HMO not covered by state's peer review protection act because is not a direct practitioner of health care or health care facility administrator.*
- (3) *Watch for CVO collecting peer review information on behalf of "protected entity" but then using for "non-protected entity(ies)."*
- (4) *Recommendations:*
  - (a) *Structure any disclosure between the entities within an exception or disclosure permitted by the applicable statute.*
  - (b) *Utilize a written delegation agreement, and if appropriate under applicable state law, designate the delegated entity as "agent" of the*

*delegating entity - may enable actions and information generated pursuant to delegation to be encompassed within privileges applicable to the delegating entity.*

- (c) *Include provisions in the agreement and/or to accompany disclosed information that: (i) the information generated pursuant to delegation is privileged; (ii) the receiving entity agrees to maintain the information as confidential; and (iii) disclosure is not intended to waive any applicable privileges of confidentiality.*
- (d) *Be careful about "promising" confidentiality to those disclosing information.*

2. *Final Decision-Making Authority. The delegated credentialing arrangement should be structured to maintain decision-making authority with the delegating entity as necessary for compliance with legal and accreditation requirements. In any form of delegation, there should be an evaluation of whether delegation will jeopardize licensure and accreditation requirements of the delegating entity and, if licensed, the delegated entity.*

a. *Key standards:*

*JCAHO/Networks LD 3.4: MCO must retain prerogative to make key decisions.*

*JCAHO/Hospitals MS.5: The organization establishes mechanisms for hospital-specific appointment and reappointment of medical staff members and for granting and renewing or revising hospital-specific privileges.*

*NCQA/MCOs CR 13.2: MCO must retain right to approve new practitioners, providers and sites, and terminate or suspend individual practitioners.*

b. *Recommendations: Specify in the contract or credentialing policies and procedures the precise scope of credentialing activities pursuant to delegation and who has decision-making authority as necessary to comply with accreditation standards of delegating entity. Maintain appropriate oversight authority for the delegating entity.*

3. *Immunity. The delegated credentialing arrangement should be structured to invoke immunity for credentialing decisions for both the delegating entity and the delegated entity to the extent possible. This is particularly important if the delegation includes any aspect of decision-making, rather than just generation of information.*
- a. *In structuring delegation of credentialing, the delegating entity and the delegated entity should ensure that the activities will be protected by state immunity protections for peer review as well as that available under the Health Care Quality Improvement Act (HCQIA), 42 U.S.C. Sec. 11101 et seq. Key in determining if immunity can be invoked will be the type of entity and the type of activity.*
- b. *HCQIA provisions.*
- (1) *Immunity is afforded for a professional review body, ... persons under contract or formal agreement with the body, any person participating with or assisting the body, if the professional review action is in accord with the four standards specified in Section 11112(a) (reasonable belief, adequate notice and hearing, etc.). Sec. 11111(a)(1) (emphasis added).*
- (2) *A person providing information to a professional review body regarding a practitioner's competence or conduct is not liable for damages under any law, unless the person knew the information was false. Failure to report a professional review action is an exception to immunity. Sec. 11111(b).*
- c. *Analysis involves the immunity of the entity delegating the credentialing and the immunity of the delegated entity. If the delegated entity does not provide health care services itself, it will be difficult to assert that is a "health care entity" entitled to immunity. Therefore, immunity must come from the delegating entity and apply to the delegated entity because of its status as an agent for the delegating entity. The delegating entity should qualify as a "professional review body" to enable assertion of immunity for both entities.*
- d. *Keep in mind that qualifying for immunity may require reporting of professional review actions by the delegating*

*entity and (more importantly) affording the affected practitioner "adequate notice and hearing" (or such other procedures as are for under the circumstances) under HCQIA as well as meeting the other three standards.*

- e. *As with confidentiality, be careful about "promising" peer review participants immunity.*

4. *Fulfillment of MCO's Duty to afford Due Process.*

- 1. When credentialing is delegated, the delegation agreement needs to make clear what the delegated entity's responsibilities are as to affording any procedural rights of review to a practitioner/provider whose participation in the MCO is denied or is terminated.
- b. If this function is being delegated, the delegated entity should be required to comply with all legal and accreditation requirements applicable to the MCO. The MCO should have a mechanism to validate this since it may involve the legal obligations owed by the MCO to the practitioner/provider. The legal requirements applicable to the delegated entity may differ from those owed by the delegating entity, involving a change in the delegated entity's process to comply with the delegation.
- c. In the case of a provider network, distinguish between an action by the delegated entity as to membership or participation in the network compared to participation in the MCO---these may not always be the same.

5. Termination of Practitioner/Provider from Delegated Provider Network.

- 1. The delegation agreement should address the effect of termination of the relationship between a practitioner/provider and provider network on the practitioner/provider's continued participation in the MCO.
- 2. The MCO will need to be able to rely on the current credentialing by the network (and access its information) until the MCO can substitute its own credentialing for the practitioner/provider assuming he/she contracts directly with the MCO.

6. Use of Delegated Provider Network Credentialing for Other Products.

- 1. A practitioner/provider may decide to terminate his/her contract for

one of the MCO's product lines through the provider network, instead contracting directly with the MCO, but continue to access other product lines through the provider network.

2. The delegation agreement should address whether the MCO may continue to rely on the network's delegated credentialing as to this practitioner/provider for all the product lines. The network may be willing to allow this if the practitioner/provider is continuing to access other MCO products through the network.

## **VI. CENTRALIZED CREDENTIALING**

### *A. Defined.*

#### *1. Consolidation of all or a portion of credentialing process such as:*

- *application form*
- *credentialing policies and procedures*
- *information gathering and primary source verification function*
- *credentials committee investigation and review*
- *criteria for clinical privileges*
- *decision on appointment, clinical privileges and/or participating provider status (initial or reappointment)*
- *information sharing between entities*
- *corrective or disciplinary action*
- *fair hearing process*

#### *2. Examples:*

- a. Centralized appointment process for a health care delivery system's three hospitals, ambulatory surgery center, 5.01(a) corporation, and HMO participating panel.*
- b. Single consolidated medical staff for a five-hospital system.*
- c. Use of centralized medical staff office or CVO by health care delivery system components as to single application form, information gathering and primary source verification only.*

- d. *Sharing of quality assurance data and corrective/disciplinary action between health care delivery system components.*
- e. *Centralized decision-making on appointment/participating provider status, but each health care delivery system component makes own decision regarding clinical privileges.*

*B. Consider legal requirements.*

- 1. *State licensure law for hospitals/health care entities.*
- 2. *Managed care requirements/TDI.*
- 3. *BME regulations for 5.01(a) corporation.*
- 4. *HCQIA procedures for health care entities.*
- 5. *Medicare Conditions of Participation.*

*C. Reasons to Consider Centralized or Uniform Credentialing.*

- 1. *Obtaining efficiencies in time and expense for all participants.*
- 2. *Standardizing decision-making (and possibly level of quality).*
- 3. *Minimizing liability:*
  - a. *Lawsuit by provider accepted by Hospital A, but excluded by Hospital B and ambulatory surgery center (ASC) for competency reasons. Hospitals A and B and ASC are all components of single health care delivery system.*
  - b. *Lawsuit by patient injured at Hospital A under example above.*
  - c. *Lawsuit by provider where provider summarily suspended at Hospital A for competency reasons, but no action taken by Hospital B or HMO as to privileges that were summarily suspended.*
  - d. *Lawsuit by patient injured at Hospital B or HMO under example above.*

D. *Legal Issues.*

1. *Final Decision-Making Authority. Need to comply with licensure and accreditation requirements as to final decision-making authority.*
  - a. *"Upstreaming" of decision v. "downstreaming" in delegated credentialing:*
    - (1) *"Upstreaming" credentialing: credentialing for various components is moved "up" to health care delivery system or network level - example of true centralized or uniform credentialing.*
    - (2) *"Downstreaming" credentialing: MCO or health care delivery system delegates credentialing to a component or third-party CVO.*
  - b. *"Joint process" may fare better than delegating function away.*
  - c. *Watch applicable accreditation standards. Consider need for each delegating entity to retain oversight and option to override centralized credentialing decision.*
2. *Confidentiality. The system must maintain the confidentiality of information shared between health care delivery system components or generated by joint committees.*
  - a. *Examine state peer review statutes on confidentiality.*
    - (1) *Definition of "health care entity" eligible to invoke the privilege of confidentiality - will all components be eligible?*
    - (2) *Based on the definition of "peer review committee" and what information protected, is a specific structure required for centralized credentialing?*
    - (3) *Is there statutory authority to share/disclose information generated by one health care entity/committee to another without resulting in waiver of the privilege of confidentiality?*
    - (4) *Does the peer review confidentiality privilege of the*

*delegating entity extend to an agent?*

(5) *Does the peer review confidentiality privilege extend to information generated by “joint” committees or “system” committees?*

b. *Structure relationship or process within available privileges. Reference intent to perform peer review and to maintain confidentiality in key organizational documents. Establish appropriate procedures to maintain confidentiality*

3. *Immunity. The system must maintain peer review immunity for committees and participants.*

a. *Similar analysis of state peer review statutes on immunity.*

b. *HCQIA (see Section V.C.3 above).*

4. *Due Process Obligations.*

1. Each entity involved in the centralized credentialing will have different due process obligations to a practitioner/provider in the event of (1) denial of participation, and (2) termination of participation (see Section VII below).

2. These will need to be reconciled to achieve a single due process system applicable to all the entities. Inevitably, the result is that all entities afford the highest level of due process owed by the entities (which means more process for some entities than prior to the centralization).

5. Employee v. Independent Contractor. Differing status of practitioner may affect application inquiries and grounds for termination (e.g. health status).

6. Antitrust. Uniform decision-making implications may depend on market share and level of integration between participating components.

7. Causes of Action. Traditional causes of action in credentialing/privileging will still exist and potential defendants may include all components of the system.

E. **Recommended Process for Establishing Structure.**

1. Determine objectives (which may involve a mixing of delegation and

centralized credentialing).

2. Examine applicable law - what is allowed and what is not.
3. Compare whether dealing with practitioners as employees or independent contractors and legal relationship with them.
4. Examine licensure and accreditation implications of each entity.
  - a. What standards will apply and need to be reconciled.
  - b. Discuss with regulatory and accreditation agencies in advance and obtain written confirmation if possible of acceptability of proposal.
5. Look at sample structures.
6. Evaluate the “political” climate and the receptiveness of the various entities to change and perceived loss of control over own credentialing.

## **VII. SUMMARY OF DIFFERENT DUE PROCESS REQUIREMENTS**

- A. *5.01(a) Corporation, BME Regulations, 22 TAC Sec. 177.4(2)(F).*
  1. *Termination of the retention of any physician to provide medical services on behalf of the 5.01(a) corporation during the physician’s term of retention must be “subject to due process procedures.”*
  2. *The due process procedures may be adopted by the 5.01(a) corporation’s board of directors or its physician designees or may be provided by the retention agreement between the 5.01(a) corporation and the physician.*
- B. *HMO, Tex. Ins. Code Art. 20A.18A(a), (b), (d).*
  1. *Admission. The HMO must make available and disclose to physician and providers, on request, written application procedures and qualification requirements for contracting with the HMO. If there is a denial, the HMO must provide written notice of the reasons the initial application was denied.*
  2. *Termination. Before terminating a contract with a physician or provider, the HMO must provide a written explanation of the reasons for the termination.*

- a. *A physician or provider is also entitled to review of the proposed termination on request and before the effective date of the termination, but within a period of 60 days. The review is by an advisory review panel of physicians and providers including, at least one representative in the physician's or provider's same or similar specialty (if available) appointed to serve on the standing QA committee or UR committee of the HMO. (There is an exception for cases for in which there is imminent harm to patient health or an action by the licensing board or other governmental agency that effectively impairs the physicians or dentists ability to provide services or in cases of fraud or malfeasance.)*
- b. *The recommendation of the advisory panel must be considered but is not binding on the HMO. The HMO must provide the affected physician or provider, upon request, with a copy of the recommendation of the panel and the HMO's final determination.*
- c. *A physician or provider who is terminated or deselected is entitled to an expedited review process by the HMO on request.*

3. "Provider." Means any person other than a physician that is licensed or otherwise authorized to provide a health care service in Texas, or a person who is wholly owned/controlled by a provider or group of providers licensed to provide the same health care service, or a person wholly owned/controlled by one or more hospitals and physicians, including a PHO. Tex. Ins. Code Art. 20A.02(t).

3. Preferred Provider Benefit Plans, Tex. Ins. Code Art. 3.70-3C, Sec. 3.

1. Admission. A preferred provider benefit plan must provide a "fair, reasonable, and equivalent opportunity" to physicians, practitioners, institutional providers and other health care providers to become preferred providers. Designation may not be unreasonably withheld.

1. The insurer must, upon request, provide information about the application process and qualification requirements to any physician or health care provider. The insurer must give a physician or health care provider being denied initial designation as a preferred provider with a written reason for the denial.

2. If preferred provider status is withheld as to a physician or practitioner, the insurer must provide a reasonable review mechanism that incorporates an advisory role only by a review panel. The panel must be composed of not less than three physicians or practitioners selected by the insurer from preferred providers and must include one physician or practitioner in the same or similar specialty, if available. The panel's recommendation must be provided, upon request, to the affected physician or practitioner if the insurer's determination is contrary to the panel's recommendation, the affected physician or practitioner must be provided a written explanation of the insurer's determination upon request.

2. Termination.

1. An insurer, before terminating a contract with a preferred provider, must provide written reasons for termination.
2. Prior to terminating a physician or practitioner, but within a period not to exceed 60 days, the insurer must, upon request, provide a reasonable review mechanism that incorporates an advisory role only by a panel meeting the qualifications set up above. (There is an exception, just as for HMOs, in cases of imminent harm to a patient's health or an action by a licensing board or other governmental agency that effectively impairs the physician's ability to practice medicine or in cases of fraud or malfeasance.) The recommendation of the panel must be provided to the affected physician or practitioner and, in the event the insurer's determination is contrary to the panel's recommendation, the affected physician or practitioner must also be given a written explanation of the insurer's decision.
3. "Practitioner." Defined as a practitioner under Tex. Ins. Code Art. 3.70-2 or 21.52, or an occupational therapist, physical therapist or advanced practice nurse.

4. Health Care Quality Improvement Act.

To invoke the immunity protection afforded by HCQIA, the health care entity must afford "adequate notice and hearing," meaning the procedures set out in HCQIA or such other procedures as are fair to the physician under the circumstances. HCQIA limits involvement of direct economic competitors and requires 30 days for the practitioner to request a hearing and 30 days advance notice of the date of the hearing (compare to HMO requirements).

5. NCQA/MCOs.

CR11 The MCO has policies and procedures for altering the conditions of the practitioner's participation with the MCO based on issues of quality of care and service. These policies and procedures define the range of actions that the MCO may take to improve performance prior to termination.

CR 11.1 The MCO has procedures for, and evidence of implementation of, as appropriate, reporting of serious quality deficiencies that could result in a practitioner's suspension or termination to appropriate authorities.

CR 11.2 The MCO has an appeal process for instances in which the MCO chooses to alter the conditions of the practitioner's participation based on issues of quality of care and/or service. The MCO informs practitioners of the appeal process.

Rationale CR 11

All the decisions about altering the practitioner's relationship with the MCO are based on information submitted by the practitioner, as well as objective evidence. Decisions are guided by patient care considerations. Policies and procedures define the process to assure that practitioners are treated fairly and uniformly.

...

A fair hearing and appeal process allows adverse decisions to be aired and understood and errors to be corrected. Well-defined procedures that help the MCO apply the policy consistently may include defining the type of documentation to be submitted by the practitioner, criteria for decision making, the hearing schedule, and composition of the hearing panel.

6. JCAHO/Networks.

HR.3.21 The network has a defined, documented process for terminating the appointment of licensed independent practitioners.

HR.3.22 The network has a defined process for considering appeals to decisions to terminate appointment.

HR.3.22.1 Profession-specific licensed independent practitioners actively practicing in the network are included in reviewing appeals and making recommendations for action.

HR.3.22.2 All licensed independent practitioners are provided a written copy of the appeal process.

Intent of HR.3.22 Through HR.3.22.2

The network has a process for fair hearing and appeal of adverse decisions regarding continued appointment. The process complies with all applicable law. The network's fair hearing and appeal procedures are specified in the reappointment process. These procedures address scheduling and conducting hearings, the composition of the hearing panel, and the hearing agenda. The hearing panel is designed to have a mixture of disciplines, and include, at least a practitioner of the same profession as the appealing practitioner. Appropriate network leaders approve these processes.

7. JCAHO Hospital Accreditation Standards (1999).

*MS.5.2: There are mechanisms, including a fair hearing and appeal process, for addressing adverse decisions for existing medical staff members and other individuals holding clinical privileges for renewal, revocation, or revision of clinical privileges.*

*MS.5.2.1: These mechanisms may differ for medical staff members and other individuals holding clinical privileges.*