conomic Credentialing: Where Is It Going?

By Paul F. Danello of Ropes & Gray LLP

In recent years hospitals have increasingly adopted conflict-of-interest and credentialing policies that, more or less explicitly, condition the grant or renewal of medical staff privileges on patient referrals.

For example, some hospitals have attempted to staunch the loss of patients treated at ambulatory surgical centers not owned by the hospital by requiring their medical staff physicians to pledge that they do not have any "financial conflicts of interest" with the hospital. In the view of these hospitals, a physician's equity ownership in an ambulatory surgical center constitutes a "financial conflict of interest" sufficient to preclude the grant or renewal of medical staff privileges.

Some hospitals have taken a further step by restricting applicants to their medical staffs from admitting patients to other hospitals by requiring physicians who seek privileges to admit a certain percentage of patients to the hospital or to maintain privileges exclusively at it.

Such conflict-of-interest and credentialing policies, known generally as "economic credentialing", may violate the anti-kickback statute and be unenforceable.

This article addresses this phenomenon from three perspectives:

* What "economic credentialing" is,

* Its status under existing state law, and

* The OIG's emerging treatment of it under the federal anti-kickback statute.

DEFINITION OF "ECONOMIC CREDENTIALING"

There is no generally accepted definition of "economic credentialing", although the concept has been widely discussed in the literature of medical ethics and accreditation standards.1 The following definition of the American College of Medical Quality has been widely used:

Economic credentialing defines a health care professional's qualifications based solely on economic factors that are unrelated to the individual's ability to make standard of care medical review or direct clinical care decisions. It involves the use of economic criteria by a health care organization as the only factor which determines a physician's or other health care professional's qualifications for initiation, continuation, or revocation of medical care or peer review privileges. As such, economic credentialing impedes the professional's role as the patient's advocate, represents an inappropriate basis for credentialing, and is considered professionally unacceptable.

Credentialing must be the exclusive product of qualified and objective peer review, utilizing criteria directly related to the quality of patient care in which neither over- nor under-utilization of

medical resources is accepted. The decision-making process of peer review must be objective and unbiased, consistent with the standard of care in medical decision-making, and not unreasonable, capricious, or arbitrary; it must have dated, detailed documentation and be legally and clinically justifiable, performed in good faith, and equally applied to all. In cases of adverse peer review decisions, avenues of appeals utilizing due process and the inclusion of recorded fair hearings before a panel of objective peers must be available to all physicians or health care professionals being credentialed.2

The American Medical Association ("AMA") defines economic credentialing as "the use of economic criteria unrelated to quality of care or professional competence in determining a physician's qualifications for initial or continuing hospital medical staff membership or privileges."3 The AMA and a number of its state affiliates have registered strong opposition to economic credentialing.4

CURRENT LEGAL STATUS

Currently at least 19 states have enacted legislation concerning the use of economic factors in credentialing decisions. 11 states have passed legislation that restrict, to varying degrees, a hospital's ability to use economic factors in credentialing physicians.5 8 other states have passed laws that permit hospitals to engage in economic credentialing.6

There have been several recent cases where hospitals either denied privileges to physicians or refused to renew physicians' privileges on the basis that the physicians over-utilized hospital services. In all of the cases, the courts have refused to disturb the hospitals' credentialing decisions.7

THE OIG'S EMERGING POSITION

1. Existing OIG Interpretation under Anti-Kickback Statute of Credentialing

Economic credentialing policies may violate the federal anti-kickback statute and be unenforceable.8

In 1991, the Office of the Inspector General ("OIG") for the Department of Health and Human Services issued a Management Advisory Report ("MAR") that examined the financial relationships between hospitals and hospital-based physicians, such as anesthesiologists, pathologists, and radiologists, under the anti-kickback statute.9 In the MAR the OIG took the position that hospitals materially influence the flow of Medicare and Medicaid patients to hospital-based physicians and violate the anti-kickback statute if they require such physicians to provide remuneration exceeding the fair market value of services that the hospitals provide in exchange for patient referrals.10

In the MAR the OIG criticized hospitals for exacting payments or other remuneration "far in excess of the fair market value of the services provided by them" in exchange for the granting of exclusive privileges at the hospital,11 citing as examples the following instances referred to it by

"[s]everal medical societies and anonymous parties":

* A hospital provides no, or token, reimbursement to pathologists for Part A services in return for the opportunity to perform and bill for Part B services at that hospital;

* Radiologists must pay 50% of their gross receipts to a facility's endowment fund;

* 33% of all profits above a set amount must be paid by a radiology group to a hospital for its capital improvements, equipment, and other departmental expenditures;

* A radiologist group was required to purchase radiology equipment and agreed to donate the equipment to the hospital at the termination of the contract. The hospital has an unrestricted right to terminate the contract at any time;

* When net collections for a radiology group exceed $230,000, 50% is paid to the hospital, and the hospital reserves the right to unilaterally adjust the distributions if it determines that the physician group has not fulfilled the terms of the contract;

* A radiologist group pays 25% of the profits exceeding $120,000 to the hospital for capital improvements with 50% of the profits exceeding $180,000 paid for this purpose; and

* A radiology group pays for facilities, services, supplies, personnel, utilities, maintenance, and billing services furnished by the hospital on a fee schedule that begins at $25,000, and rises to $100,000. Payments are due only if the radiologist's gross revenue exceeds $1,000,000 in the previous year.12

The OIG concluded in the MAR that:

All of these examples appear to violate the statute because they provide compensation to the hospitals that exceeds the fair market value of the services the hospitals provide under the contracts. It also appears the remuneration is intended to provide the hospital-based physician with referrals from the other physicians on the hospital's medical staff.13

The MAR recommended that the Health Care Financing Administration [now the Centers for Medicare & Medicaid Services] notify hospitals about their potential legal liability when they enter into such arrangements and refer cases "similar to the examples given above or any other suspect arrangements" to the OIG for possible prosecution or sanctions.14

In addition, it might be noted that claims resulting from violation of the anti-kickback statute may constitute false claims pursuant to the federal False Claims Act.15 Several courts have held that the violation of the anti-kickback statute may also violate the False Claims Act.16 Consequently, if a hospital were to be found to have forced a physician improperly by means of economic credentialing to refer patients to it in exchange for the grant or renewal of medical staff privileges, all hospital claims for services provided to the patient could be held to be false claims. As such, these claims could potentially expose the hospital to treble damages, significant civil monetary

penalties, and exclusion from federal health care programs.17

2. OIG's Solicitation of Comments on Economic Credentialing

Three years after the American Medical Association asked the OIG to intervene in the practice of economic credentialing,18 the OIG published a solicitation in the Federal Register on December 9, 2002 requesting public comments on "certain credentialing practices."19 Official regulatory action by OIG on this issue is expected sometime in 2004. It is likely that the OIG will issue a fraud alert, a new safe harbor, or other official industry guidance that will permit economic credentialing, at least in certain circumstances, and define which practices are permissible and which are suspect under the federal anti-kickback statute.

The OIG's December 9, 2002 solicitation included a number of hints that signal its approach to resolving this thorny problem. The threshold question raised by the OIG was: "Are hospital staff privileges 'remuneration'?" The OIG noted the impact of the growth of managed care networks, especially in combination with the growth of health care systems that substantially control local markets and the potential that access to patients may depend on having privileges at a network hospital.

The OIG asked for comment as to whether privileges have value in all cases or only in such markets where privileges affect access to patients. The case law in most jurisdictions throughout the country indicates that the courts have historically not considered medical staff privileges to be a property right, although legal precedent does exist for the argument that medical staff privileges or any other status that confers access to potential markets may have value capable of constituting "remuneration" for anti-kickback purposes and may support an anti-kickback violation.20

The OIG's solicitation also examined the implications of a hospital's denial of privileges to physicians who compete with the hospital. In this regard, the OIG stated its position explicitly: "A credentialing policy that categorically refuses privileges to physicians with significant conflicts of interest would not appear to implicate that anti-kickback statute in most situations." If, as expected, the OIG maintains this position, the only question that would remain to be addressed in a fraud alert, a new safe harbor, or other official industry guidance would be how such conflicts of interest should be defined, e.g., in terms of ownership in a competing facility, employment or contractor status, or the incumbency of a medical staff leadership position.21

The OIG suggested that an economic credentialing practice that provides for discretion by a hospital may negatively affect the analysis under the anti-kickback statute because discretionary decisions may be volume-sensitive. In such cases, the OIG states: "Such discretionary decision-making appears to raise substantial risks under the anti-kickback statute (i.e., privileges are conditioned on a sufficient flow of referred business)." The OIG has requested comments as to whether sufficient safeguards could temper such discretion. Some commentators and interested parties have maintained that special scrutiny of discretionary policies is warranted, citing instances where hospital first insisted that its staff members disclose all outside relationships, then subjected physicians' referral patterns to intensified review for a probationary period (under undisclosed standards) if they disclosed what the hospital deemed to be a conflict. These commentators and

interested parties have argued that the potential for abuse is clear in circumstances where a failure to refer enough of the right kind of patients (i.e., those with the best insurance coverage) could be used as justification for a decision not to re-credential the physician.

The OIG reserved its sharpest criticism for "geographic exclusivity" arrangements that condition privileges on meeting certain levels of referrals beyond minimums necessary for clinical proficiency. The OIG stated, "Assuming the privileges have monetary value, such conditions would appear to be suspect under the anti-kickback statute." Still, the OIG asked if there could be conditions under which such conditions might be justified, such as a hospital's failing financial health or in exchange for offering a critical service not otherwise available, thereby implying that it would consider the practices permissible in these circumstances.

As the OIG reviews the comments that have been submitted by both advocates and opponents of economic credentialing, it may, of course, have reason to change the initial positions stated in its December 9, 2002 solicitation of comments. Several interested parties have seen fit to release their comments to the OIG for public dissemination.

Nonetheless, it is likely that the OIG will (1) permit some level of economic credentialing of physicians who own facilities that compete against hospitals in which the physicians have medical staff privileges, (2) prohibit referral quotas, and (3) analyze other arrangements on a case-by-case basis.

Footnotes

1. See Opinions of the Ethics Committee on the Principles of Medical Ethics. 5th ed.. Washington, DC: American Psychiatric Association, 1993, Section 1-B: 5; Policy Manual 1994-1995. The American Society of Internal Medicine, Washington, DC.: 82, 94-95; By-laws and Digest of Council Actions. American College of Radiology, 1993, Section II:186-187; American Medical Association Council on Long Range Planning and Development in cooperation with the Council on Constitution and Bylaws. Policy Compendium of the American Medical Association. Chicago: The American Medical Association, 1995, 387-390, 647, 649; Standards, Guidelines and Statements. The American Society of Anesthesiologists, October, 1994, 35; Statement of Principles. American College of Surgeons, March, 1994, 6-7; Resolutions 808, 812-Physician Profiling, American Medical Association, June 1995, 83; Comprehensive Accreditation Manual for Hospitals. Chicago: Joint Commission for the Accreditation of Health Care Organizations, 1996. 490, 492; Code of Medical Ethics. Chicago: Current Opinions of the Council of Ethical and Judicial Affairs, 1996-1997 Ed. American Medical Association, 4.07, 9.05; Compendium of AAFP Positions on Health Care Issues. Kansas City, Mo.: American Academy of Family Practitioners, 1994-95, 64; Standards for Obstetric-Gynecological Services. 6th ed. Committee on Professional Credentialing Privileges, American College of Obstetrics and Gynecology, 1985, 7; American College of Physicians Ethics Manual, Annals of Internal Medicine. 1992;117:947-960; National Network Accreditation Standards. The American Accreditation Health Care Commission, formerly the Utilization Review Accreditation Commission, April 1996; Standards for Accreditation 1997. Standards for Credentialing and Re-credentialing, National Committee for Quality Assurance, 39-55; California Business and

Professions Code Â§ 809.1-5; Muse v. Charter Hospital of Winston-Salem, Inc. 452 SE2d 589, aff'd 464 SE2d 44 (1995); Committee on Gynecologic Practice. Credentialing Guidelines for New OperationalProcedures. Washington, DC: American College of Obstetricians and Gynecologists, August 1994.

2. See http://www.acmq.org/profess/policy19.htm. See also http://www.projectphysicianquality.org/Definitions.htm.

3. See AMERICAN MED. ASS'N POLICY COMPENDIUM 230.975, at 197 (1993).

4. See AMERICAN MED. ASS'N POLICY COMPENDIUM 230.975, at 197 (1993) ("The AMA strongly opposes the practice of economic credentialing."). The AMA's then Executive Vice President, E. Ratcliffe Anderson, wrote a letter dated December 11, 1999 asking the Department of Health and Human Services, Office of Inspector General, to declare that certain economic credentialing practices violated federal law. See Thorn Wilder, "AMA Calls Exclusive Credentialing By Hospitals a Fraud Violation," 9 Health L. Rep. (BNA) 344 (March 9, 2000).

5. See CAL. WELFARE AND INSTITUTIONS CODE Â§ 14087.28 (denial of medical staff membership or clinical privileges); COLO. REV. STAT., Title 25 Â§ 25-3-103.7 (employment of physicians); D.C. CODE ANN. Â§ 32-1307 (standards for clinical privileges and staff membership; anti-competitive practices prohibited [New statute - DC STAT. 1981 Â§ 44-507]); IDAHO CODE Â§ 41-3920 (discrimination against health professionals associated with managed care organizations); ILL. REV. STAT. Ch. 210, 85/2(b); LA. REV. STAT. ANN. Â§ 37:1301 (nonprofit hospitals; discrimination prohibited); MASS. GEN'L L. Ch. 111, Â§ 51C (applications for staff membership or clinical privileges; discrimination); R.I. GEN. LAWS Â§ 23-17-52 (physician contracts); TENN. CODE ANN. Â§Â§ 68-11-205, 68-11-227; TEX. HEALTH AND SAFETY CODE ANN. Â§ 241-1015; VA. CODE ANN. Â§ 32.1-134.1 (when denial to duly licensed physician of staff membership or professional privileges improper).

6. See FLA. STAT. Ch. 395-0191 (staff membership and clinical privileges); GA. CODE ANN. Â§ 31-7-7 (refusal or revocation by public hospital of staff privileges); IND. CODE Â§ 16-21-2-5 (responsibilities of hospital governing board); IOWA CODE Â§ 135B.7 (rules and enforcement); KAN. STAT. ANN., Â§ 65-431 (selection of professional staff; hospital compliance through combined operation); MD. CODE. ANN., HEALTH GEN. Â§ 19-319 (qualifications for licenses); N.Y. PUBLIC HEALTH LAW Â§ 2801-b (improper practices in hospital staff appointments and extension of privileges prohibited); N.C. GEN. STAT., Â§ 131E-85 (hospital privileges and procedure).

7. See, e.g., Rosenblum v. Tallahassee Mem'l Reg'l Med. Ctr., No 91-589 (Fla. Cir. June 1992) (affirming a hospital's decision to deny open-heart surgical privileges to a cardiologist who directed the open-heart surgical program at a competing hospital). See John D. Blum, Evaluation of Medical Staff Using Fiscal Factors: Economic Credentialing, 26 JOURNAL OF HEALTH AND HOSPITAL LAW 65 (1993) (discussing the Rosenblum case). See also Knapp v. Palos Community Hosp., 465 N.E.2d 554 (Ill. 1984), cert. denied, 493 U.S. 847 (1989); Friedman v. Delaware County Mem'l Hosp., 672 F. Supp. 171 (E.D. Pa. 1987), aff'd, 849 F.2d 600 (3d Cir.

1988); Hassan v. Independent Practice Assoc., 698 F. Supp. 679 (E.D. Mich. 1988) (upholding IPA's decision to terminate allergists who over-utilized tests based on goal of containing cost); Edelman v. John F. Kennedy Mem'l Hosp., No. C02104080 (N.J. Super. 1982), cert. denied, 475 A.2d 585 (N.J. 1984).

8. 42 U.S.C.A. Â§ 1320a-7b(7).

9. Department of Health and Human Services, Office of Inspector General, Management Advisory Report, No. OEI-90-89-00330, Financial Arrangements Between Hospitals and Hospital-Based Physicians (Oct. 21, 1991) reproduced at http://oig.hhs.gov/oei/reports/oei-09-89-00330.pdf.

10. Ibid. at 1-2. The AHA opposed the MAR on the grounds that hospitals did not "refer" patients to hospital-based physicians and that there was no evidence of over-utilization. See Letter from Paul C. Rettig, American Hospital Association to Richard B. Kusserow, Inspector General, dated March 11, 1991 (attached as Appendix B to the MAR); Letter from Richard J. Pollack, American Hospital Association to Richard R. Kusserow, Inspector General, dated September 6, 1991 (attached as Appendix B to the MAR).

11. Ibid. at 1.

12. Ibid. at 3-4.

13. Ibid. at 4.

14. Ibid. at 5.

15. 31 U.S.C.A. Â§ 3729 et seq. The Federal False Claims Act empowers any person with knowledge of a fraud scheme against the government to bring suit on the government's behalf and to collect up to 30% of the ultimate reward. See 31 U.S.C.A. Â§ 3730.

16. See United States ex rel. Thompson v. Columbia/HCA Healthcare Corp., 938 F.Supp. 399 (S.D. Tex 1996), aff'd, 125 F.3d 899 (5th Cir. 1997); United States ex rel. Pogue v. American Healthcorp, Inc., 914 F. Supp. 1507 (M.D. Tenn. 1996).

17. See 31 U.S.C.A. Â§ 3731 (damages under False Claims Act); 42 U.S.C.A. Â§ 1320a-7 (mandatory exclusion).

18. See note 4 supra.

19. 67 Fed. Reg. 72,894-6 (Dec. 9, 2002).

20. For example, in U.S. v. Bay State Ambulance and Hosp. Rental Service, Inc., 874 F.2d 20 (1st Cir. 1989), the First Circuit Court of Appeals stated, "Giving a person an opportunity to earn money may well be an inducement . . . to channel potential payments towards a particular

recipient."

21. Some commentators and interested parties have contended that the OIG's pre-judgment of one of the most contentious aspects of the exclusive credentialing debate is troubling. These commentators and interested parties argue that physicians often invest in new technology in markets in which hospitals are reluctant to do so and that "penalizing" such physicians through economic credentialing may have the unintended consequence of restricting patient access to such new technology, to physicians who invest their own funds to introduce such technology to their communities, or to both. The OIG has not found such arguments persuasive.