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Economic Credentialing—An Idea Whose Time Has Come?

Overview

The term *economic credentialing* is an old phrase that carries different meanings for different people, especially physicians. Simply stated, it is typically defined as any medical staff credentialing decision that is based solely on economic or financial factors unrelated to a physician's professional qualifications. To engage in economic credentialing has been seen as sacrilegious by most physicians, and such practices have been almost uniformly challenged by medical staff bylaws or any other medical staff rule, regulation, or policy.

Yet medical staff membership decisions based on economic factors vary widely among organizations, and some economic-based decisions have been in common use for many years. For example, exclusive contracts with hospital-based groups such as anesthesiologists, pathologists, and radiologists, which preclude physicians from applying for membership, have been the norm for at least two decades. Although they were challenged as anticompetitive and therefore a violation of state and federal antitrust laws, courts have universally upheld these agreements based on the argument that patient care is improved as a result of better continuity of treatment, 24/7 coverage, greater efficiencies, and other similar factors that are present when exclusive contracts are in place.

But what about some examples of what I call pure economic credentialing practices, in which the connection to improving quality is questionable

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and the decision is almost exclusively financial? Are such practices still to be considered sacrilege, or rather, in light of rapidly changing healthcare industry dynamics, are the decisions made on the sole basis of financial factors becoming more acceptable?

Appointment Decisions Based on Economic Factors

The extent of merger and acquisition activity and clinical integration at all levels has never been higher, and more is expected. Any stand-alone or unaffiliated hospital, even in a rural area, has been or will be forced to consider whether it can survive in a rapidly changing environment where access to capital is limited and reimbursement is based on the value of services provided rather than the volume. The Affordable Care Act mandates the reduction of Medicare and Medicaid payments, and private payers are following suit. Meanwhile, both the government and private payers expect to see decreased utilization and the achievement of high quality standards based on pay-for-performance measures. Many physicians now eagerly, if not frantically, approach hospitals to purchase their practices or to join a hospital staff as an employee, especially younger physicians coming out of their residency programs. Otherwise, depending on the marketplace in which they practice, physicians often join megagroups in an attempt to remain “independent.”

One might therefore ask, How does a hospital make a credentialing or membership decision without taking economics into consideration? For example, what action should a hospital and medical staff take if it receives an application request from a physician who is employed by or whose practice was recently purchased by a competing health system that is aggressively purchasing practices in the hospital’s primary service area? The assumed goal of the applicant is to attract business away from the hospital and refer or admit patients to its hospital employer. What if the applicant owns a competing surgicenter or just became a member of a competing ACO?

Under these scenarios, it arguably would be economically imprudent to place these physicians on the medical staff. But is denial of membership illegal or susceptible to a successful legal challenge? A number of courts have addressed such challenges and have supported the hospital’s decision to deny a physician’s request for an application or the actual application based on the hospital’s duty of care and legal right to exercise reasonable business judgment so as to protect the hospital’s financial viability and mission to serve its patient community.

But how far can a hospital go in its denials of membership on the basis of economic factors? As a general rule, a hospital and medical staff have the most legal leverage on the front end—before a physician becomes a member of the medical staff. Courts usually do not even exercise jurisdiction in initial application disputes as long as the hospital follows its own bylaws and is not engaged in pure discriminatory, as opposed to financial, activity. Physicians do not have a legal right to obtain membership at a private hospital; even if denied the economic benefits that may accrue from being given privileges and access rights, the denial does not equate to antitrust injury or true injury to competition.

But let's say that a hospital does not want to accept a physician who has a high Medicaid and indigent care patient load and therefore is not likely to generate positive revenue for the hospital. Hospitals that receive Medicare and Medicaid payments are required to staff a sufficient physician population willing to treat Medicaid patients in its community by specialty. Therefore, denial could be challenged on different grounds than denial of a physician's right to make money.

A more likely scenario in which denial would go unchallenged in light of the shift from volume to value is where the physician applying has a record of high or overutilization. Hospitals now commonly distribute periodic reports to physicians that provide the following information: average length of stay, cost per patient visit, number of medication orders and whether they are for generic or brand-name drugs, number of referrals made, consultants used, and other metrics. This information is likely available upon request from other hospitals considering an applicant for privileges. If the applicant indeed demonstrates a pattern of overutilization and has shown no improvement, unless she has some unique skill or practices in a needed specialty, why would the hospital employ this person or place her on the medical staff? Why take the economic risk? I believe a decision to deny an application or a membership to this individual is prudent and defensible.

Reappointment Decisions Based on Economic Factors

Whereas applicants to a medical staff generally have no legal rights, just the opposite is true for current medical staff members. Once a physician is on staff, he is typically entitled to all the rights and privileges afforded to other medical staff members, including rights to a fair or judicial hearing and appellate review. Moreover, decisions that affect a physician's privileges and membership are based on the bylaws, rules, regulations, and policies of

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the medical staff, which most likely do not recognize or permit termination for failure to be competitive in the marketplace or for employment by a competitor. Unless the hospital's decision to terminate or adversely affect privileges is based on quality of care or disruptive behavior considerations, especially without a hearing, it will likely be challenged and could attract the attention of the AMA and the state medical society.

Such was the case in *Baptist Health v. Murphy*, mentioned earlier in this chapter. Here, the hospital board of directors unilaterally adopted a conflict-of-interest policy whereby all existing medical staff members and their family members had to divest themselves of any financial, economic, or ownership interest in a competing hospital. If current members did not divest, they would not be reappointed; potential new members who held such interests would not be given applications. Five physicians sued, arguing that the policy violated the federal anti-kickback statute, the Arkansas Medicaid Fraud Act, the Arkansas Medicaid False Claims Act, and the Arkansas Deceptive Trade Practices Act and that it illegally interfered with the physician–patient relationship. The case received much attention and ultimately was decided by the Supreme Court of Arkansas, which held in favor of the five physician plaintiffs, who had a direct or indirect investment interest in the competing Arkansas Heart Hospital.

Several unique factors in the Baptist case led to this outcome. One key finding reached by the court hinged on the fact that the policy was unilaterally adopted by the board based on unsubstantiated claims about the dire financial impact that would result if the physicians did not divest or were permitted to remain on the staff when, in fact, the hospital had an extremely strong financial performance. Another finding was that physicians could be terminated without a hearing. One physician testified that she was threatened with termination even though her husband, not she, had an interest in Arkansas Heart Hospital. The husband was threatening her with divorce if she did not accept termination.

While the Baptist case has limited precedential impact in other jurisdictions, it does reinforce the difficulty a hospital will have in trying to adversely affect the membership and privileges of existing physicians without some form of hearing and without support for this action in the hospital bylaws. While the challenge is not insurmountable and some legal arguments support such decisions by a hospital, the political repercussions and legal expenses associated with defending a challenge are substantial.

Common-Sense Economic Credentialing

While I doubt that there is a single approach around which consensus can be reached when considering economic factors in credentialing decisions, the reality is that hospitals and physicians are inextricably bound together as the healthcare industry continues to consolidate and rapidly evolve as a result of reform initiatives. The current model is not sustainable. And while many hospitals are slowly moving toward an employed medical staff or a foundation-type model of employment, others will maintain an independent medical staff for a while to come. In the interim, and perhaps for a very long time, a cooperative and symbiotic—common sense—approach should be considered. Key elements of successful economic credentialing include the following:

Sharing economic, quality, and related information with the medical staff.

Physicians are not trained to run hospitals or determine what impact their practices have on the bottom line. Yet when given the right amount of information, most will typically adjust their practices to reduce unnecessary or redundant utilization and alter other behaviors that can adversely affect the hospital's finances and, in turn, its ability to hire nurses, recruit physicians, purchase equipment, and so on. Hospitals need to go over this information with physicians and develop a two-way relationship that takes into account the physician's perspective and any potential adverse impact that adjustments may have on patients. Progress on improvement should be monitored and additional support provided to assist lagging physicians in achieving clearly stated goals.

Coordinating with medical staff leaders. Any effort to inform and educate the medical staff will fail unless these efforts are coordinated with medical staff leaders. Some of the best information to be obtained in terms of cost impact and better, more efficient practices comes from physicians directly. Having informed medical staff leaders who can advise on how to best work with the medical staff greatly facilitates implementation of a plan or policy designed to reduce costs while maintaining—if not improving—quality.

Developing and implementing a performance improvement plan. Just as hospitals have developed OPPE and FPPE plans for physicians to address quality-of-care concerns, so should plans be adopted to help physicians improve practices that are out of line with their peers relating to utilization, average length of stay, cost per patient visit, and other relevant factors. The emphasis of these plans should be on education and not the imposition of disciplinary measures.

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If performance does not adequately improve to within an acceptable range, progressive remedial measures should be considered that do not trigger traditional hearing rights, as a reduction, suspension, or termination of privileges does. These measures could include taking the practitioner off the physician referral list, limiting and possibly excluding her from a managed care plan, and limiting or excluding her from ACO participation.

Considering disciplinary measures. As is true with quality-of-care concerns, the collective goal of the hospital and medical staff should be to find ways to get the physician back on track so that true disciplinary measures can be avoided. Only the attorneys benefit if you are forced down the hearing and litigation path. While other options, such as proctoring, monitoring, and requiring consultations, are effective and should be used when dealing with repeated quality-of-care concerns, they are not useful if the physician consistently fails or refuses to adjust his practice to adhere to norms and standards embraced by both the hospital and medical staff.

The biggest question is whether, under the right circumstances and when all other remedial efforts have failed, the medical staff is willing to support termination or suspension of a physician's membership and privileges. Such a decision is not reportable to the state medical society if it is made on the basis of financial or economic factors rather than quality-of-care problems; a physician's licensure will not be adversely affected. The physician may have problems linking up with a new medical staff, physician group, or ACO if seen as a recidivist overutilizer, but that outcome is not assured.

Although a hospital should make every effort to work with the medical staff to develop a policy or plan and incorporate it into the medical staff bylaws, if it is not successful in this attempt, the hospital's choices are to (1) impose measures, such as those mentioned here, that fall short of taking away privileges or (2) proceed with suspension or termination with the understanding that some kind of challenge is likely to occur. While I do not necessarily advocate the second path, steps to consider when taking this course of action include the following:

1. *Document, document, document.* Documentation should include the plan or policy adopted, how the metrics were developed, the decision to use a performance improvement plan, and how the physician failed to improve or meet the standards despite efforts to assist him.

2. *Provide a hearing.* Assuming that the medical staff will not support or recommend termination for utilization or economic factors, an administrative hearing should be provided in lieu of a medical staff bylaw hearing. If possible, engage willing physicians to participate and afford the same rights as given under the medical staff bylaws for the administrative hearing. An appeals process is not required by law but can be considered.
3. *Update board bylaws or policy.* The administrative hearing process should be formally developed and adopted by the governing board and referenced in the corporate bylaws or a board policy.

The development of a shared vision between hospitals and physicians that takes into account the financial realities of all parties is fundamental to establishing and implementing a successful strategic plan in this highly competitive and volatile market. Recognizing that all credentialing decisions have some degree of economic impact that can either benefit or undermine the entire enterprise is the first step in creating a balanced approach to membership decisions, whether on a medical staff, in an ACO, or for another clinically integrated entity. The financial resources of all parties are already strained; engaging in continued debates and challenges over whether privileging decisions, such as those based on economic credentialing, are illegal will solve little.