

CONFLICT OF INTEREST CREDENTIALING

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Physicians are feeling the pressures of practicing medicine. These pressures range from the financial pressure from decreasing reimbursement to the quality of life pressure from an increased workload designed to make up for lost dollars.

To help alleviate this pressure, many physicians are taking steps to create new revenue in their practices or otherwise supplement their incomes. For example, more physicians are acquiring, or considering acquiring, an ownership interest in freestanding healthcare facilities.

In many cases these freestanding healthcare facilities are in direct competition with hospitals for services such as outpatient surgery, diagnostic, imaging, etc. Physicians' attempts to increase their revenue have created a potential show down between physicians and hospitals. Hospitals have no choice but to respond to this new economic threat posed by those individuals most critical to the viability of their organization – their physicians.

In addition to ownership interests in freestanding facilities, physicians have also sought new types of joint ventures and other strategic relationships with hospitals. These relationships can also be viewed as problematic for affected competitor hospitals.

Many hospitals are responding to this threat by exploring increasingly aggressive strategies to minimize the impact of competitive physician activities. These hospitals are drawing the proverbial "line in the sand" and asking physicians to choose a side - either you are working with us, or you are working against us, such hospitals say. While some commentators have criticized the hospitals for taking such a position, a view of the healthcare landscape reveals that such action may be a prudent course of action, and in some markets, it may be necessary to preserve the viability of certain hospitals.

This article outlines the increasing need for a new hospital strategy, often referred to as conflict of interest credentialing or a modified version of economic credentialing, and discusses the implementation of this strategy. The result of this analysis, we believe, is that hospitals are justified in protecting the integrity of their institutions through conflict of interest credentialing, and that, if implemented properly, such strategies have been and will continue to be upheld in the courts.

I. WHY IS CONFLICT OF INTEREST CREDENTIALING NECESSARY?

Although hospitals have always competed against other similar healthcare institutions, a new competitive threat has recently emerged in the healthcare landscape – freestanding specialty facilities. These facilities, usually in the form of ambulatory surgical centers (“ASCs”) or diagnostic/imaging centers, are often owned wholly or through joint ventures by groups of physicians. Through ownership in these freestanding facilities, the physicians claim that they can improve the quality of care they provide because they will control the entity providing the care. Perhaps the more accurate reason for this wave of physician entrepreneurship is the fact that by owning a piece of the facility that provides the care, the physician owner can now share in the profit created by the facility. These ventures enhance physicians’ revenue opportunities beyond the professional component. This additional source of revenue helps to alleviate some of the Physicians’ personal and professional pressures.

Physicians’ relationships with competing hospitals also create the potential need for conflict of interest credentialing. In addition to developing aggressive strategies like conflict of interest credentialing, hospitals are also offering physicians various joint venture opportunities as a means of minimizing the impact of physician competition. Because the joint venture relationships may involve physicians who are members of the medical staffs of multiple hospitals, the impact of the joint venture could be negative to competing hospitals. Accordingly, hospitals are being forced to look at these physician hospital joint ventures when physicians seek medical staff privileges.

An alarming result of this physician entrepreneurship is that the physicians who have an ownership interest in these freestanding facilities or special relationships with hospitals are often “cherry picking” the best patients for treatment at the freestanding facility or the related hospital. In this case, “best patients” refers to those patients with the ability to self-pay or who have preferred private insurance. By treating only those patients with the ability to self-pay or with private insurance and who are less likely to have complications, these freestanding facilities and related hospitals are leaving competing hospitals in the unenviable position of treating those patients with the lowest levels of reimbursement and who are the most costly to treat. Charitable and community hospitals normally do not have the ability or desire to turn away patients based on ability to pay. This siphoning of profitable procedures from the hospitals to either freestanding facilities or hospitals that have a special relationship with the referring physician is a direct threat to the financial stability of the hospitals. This trend directly threatens the health of the hospitals around the country. And as the health of these hospitals falters, so does their ability to protect and provide care for the health of their patients. Indeed, patient safety could also be threatened when physicians begin making decisions based directly or indirectly on ownership interest rather than quality of care criteria. The federal government recognized the potential for this problem when it enacted the federal Stark law in 1991.¹

When faced with this argument, physicians invariably argue that they would never alter their patient referral patterns for economic reasons and that the main factor

¹ 42 USC § 1395nn(a)(1)(A) (2000); See also U.S. GENERAL ACCOUNTING OFFICE, MEDICARE: REFERRALS TO PHYSICIAN-OWNED IMAGING FACILITIES WARRANT HCFA’S SCRUTINY, GAO/HEHS-95-2 (October 20, 1994).

in decisions on where a patient should receive care is all related to the quality of the care. While this physician owned facility phenomenon is fairly new, it seems very naive to assume that a physician's ownership interest in or contractual relationship with a facility will not have an impact on his or her decision-making regarding where to send the patient.

In October, 2003, the United States General Accounting Office ("GAO") issued a report to Congress titled "Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance."² In this report, the GAO found that 70% of the specialty hospitals it reviewed had some degree of physician ownership.³ The report also noted that "21 out of 25 specialty hospitals treated a lower percentage of patients who were severely ill compared with patients in the same diagnosis categories treated at general hospitals in the same urban areas."⁴ Additionally, the report found that specialty hospitals treated a smaller percentage of Medicaid patients, patients accounting for some of the lowest levels of reimbursement available, than general hospitals, noting the "marked" difference in the levels of public program patients treated by specialty hospitals versus general hospitals.⁵

As hospitals reorganize and streamline their strategic plans in order to combat the effects of the rising cost of healthcare coupled with the reduction in reimbursement, it is vital that the hospitals be able to rely on the most critical component of their institutions – their medical staff – when they chart their strategic course for the future. In these difficult and uncertain times, it is critical that physicians participate in this strategic planning process along with the hospital. It is impossible, however, for physicians to participate in this process if they have financial conflicts of interest caused by their ownership interest in facilities directly competing with the hospital or if they have a financial or other special relationship with a competing hospital. Conflict of interest credentialing policies ensure that hospitals are developing strategic plans with the input of those physicians who are bonded with the hospital through loyalty and a shared sense of purpose. More and more hospitals are using the "carrot and stick" philosophy when dealing with physicians. Under this theory, conflict of interest credentialing policies are the "stick", while joint venture opportunities between hospitals and physicians are the "carrot."

II. WHAT IS CONFLICT OF INTEREST CREDENTIALING?

Conflict of interest credentialing occurs when a hospital inquires about a physician's relationship with other hospitals or freestanding entities that are in competition with the hospital to which the physician is seeking or maintaining medical staff privileges. This inquiry can occur as part of the normal credentialing process at the time that the physician is applying or reapplying for privileges or at any time that the

² GAO-04-167 (October 2003).

³ Id. at 9.

⁴ Id. at 7-8.

⁵ Id. at 20.

physician is a member of the hospital's medical staff. The inquiry is often done by submitting to the physician written questions addressing the nature of the physician's relationships with other hospitals or healthcare entities.

The governing body of the hospital will review the answers to the questions submitted to the physician to determine if a conflict of interest exists as a result of the relationship. If it does, then the physician can be denied medical staff privileges or removed from the medical staff in the case of active medical staff members. There are often appeal rights afforded to affected physicians, including due process notice and hearings.

There are no standardized definitions or examples of what constitutes a conflict of interest because every hospital has to examine their own specific situation to make that determination. The governing bodies of hospitals are empowered to use their discretion to steer the hospital on a course that is in the best interest of the hospital and the patients it serves. Reasonable use of this discretion is an integral part of conflict of interest credentialing. Conflict of interest credentialing will not be a viable strategy for every hospital and should not be considered a "magic bullet" for dealing with competitive threats.

III IMPLEMENTING CONFLICT OF INTEREST CREDENTIALING POLICIES.

The viability of conflict of interest credentialing will be determined on a state-by-state basis. Almost 20 states have passed statutes addressing a hospital's ability to consider economic factors in the credentialing process, with over half of these states restricting, to varying degrees, a hospital's ability to consider such factors, and other states expressly allowing for such consideration.⁶

Two cornerstones supporting conflict of interest credentialing plans are the principles that: 1) a hospital has the right to conduct its business, as it deems necessary; and 2) medical staff privileges are not an entitlement.

Accordingly, each hospital's board of trustees should independently adopt conflict of interest credentialing policies if the board deems it to be in the entity's best interest. These policies should be adopted independent of the hospital's medical staff bylaws in order to provide flexibility for the organization and justification for the policies. The board of trustees of the hospitals should have the power to adopt and implement these policies without seeking permission from the hospital's medical staff.

⁶ See, e.g., CAL. WELF. & INST. CODE § 14087.28; COLO. REV. STAT. ANN. § 25-3-103.7; D.C. CODE ANN. § 44-507; FL. STAT. ANN. § 395.0191; GA. CODE ANN. § 31-7-7; IDAHO CODE § 41-3920; 210 ILL. COMP. STAT. § 85/2(b); IND. CODE § 16-21-2-5; KAN. STAT. ANN. § 65-431; LA. REV. STAT. ANN. § 37:1301; MD. CODE ANN., Health Gen. § 19-319; MASS. GEN. LAWS ch. 111 § 51C; N.Y. PUBLIC HEALTH LAW § 2801-b; N.C. GEN. STAT. § 131E-85; R.I. GEN. LAWS § 23-17-53; TENN. CODE ANN. §§ 68-11-205, 68-11-227; TEX. HEALTH & SAFETY CODE ANN. § 241.101; VA. CODE ANN. § 32.1-134.1.

From a legal perspective, hospitals should use an implementation process that is similar to the process that a hospital uses when it closes part of its medical staff because of the development of an exclusive agreement with a physician group. In many states, it is recognized by the courts that hospitals have the right to enter into exclusive contracts with certain physician groups, even if this results in a closure of part of the medical staff to other physicians who are not part of the medical group with the exclusive agreement.⁷ The use of exclusive contracts, and corresponding closure of the medical staff, have been deemed legal in these states based on the hospital's inherent right to conduct its independent business affairs without seeking permission or consent from its medical staff.

When hospitals consider the use of a conflict of interest credentialing policy, it should proceed in a measured and deliberate manner. In many cases, a small study committee appointed by the hospital's board will be selected to look at this issue and to make a recommendation. A hospital should consult legal counsel during this entire process to ensure that each step is carefully and properly documented in order to refute arguments that the policy was adopted in an arbitrary or capricious manner.

Another key aspect of successful implementation is communication with the hospital's medical staff. The hospital should explain the need for the policy and how it will be implemented long before it becomes effective. These types of policies are understandably unpopular, but the hospital must maintain open lines of communication with its medical staff during the implementation process.

Once a hospital has determined the need for a conflict of interest policy, it should provide ample notice of the adoption of the plan prior to its implementation. Communication is essential to implementing successfully these types of unpopular policies because it is critical that the medical staff understand that the hospital is attempting to protect its ability to provide healthcare to the patients that it serves.

IV. CHALLENGES TO CONFLICT OF INTEREST CREDENTIALING POLICIES.

As these types of credentialing policies are implemented throughout the country, physicians have begun challenging the legality of the policies. Their primary arguments are that such policies violate the federal anti-kickback statute and breach their contracts with the hospital. The physicians argue that these policies are a direct attempt by the hospitals to affect patient referrals. The physicians argue that, in exchange for the referrals, the physicians will be allowed to remain on a hospital staff, and that such an arrangement violates the anti-kickback statute.

⁷ See Howerton v. Grace Hosp. Inc., 96 F.3d 1438 (4th Cir. N.C. 1996); Drs. Steuer and Latham, P.A. v. Nat'l Med. Enter., Inc., 846 F.2d 70 (4th Cir. S.C. 1988); Redding v. St. Francis Med. Ctr., 255 Cal. Rptr. 806 (Cal. Ct. App. 1989) (upholding a hospital's right to enter into an exclusive contract); Garibaldi v. Applebaum, 742 N.E.2d 279 (Ill. 2001); Dutta v. St. Francis Reg'l Med. Cent., 867 P.2d 1057 (Kan. 1994); Bartley v. E. Maine Med. Ctr., 617 A.2d 1020 (Me. 1992) (holding notice and hearing provisions not triggered by policy requiring exclusive contracts); Vakil v. Anesthesiology Assoc. of Taunton, 744 N.E.2d 651 (Mass. App. Ct. 2001); Tenent Health Ltd. v. Zamora, 13 S.W.3d 464 (Tex. App. 2000) (holding the exclusive contract in this case is a valid exercise of the hospital's administrative discretion); Van Valkenburg v. Paracelsus Healthcare Corp., 606 N.W.2d 908 (N.D. 2000).

On December 9, 2002, the United States Department of Health and Human Services Office of Inspector General (“OIG”) issued a request for public comments “regarding the development of possible guidance addressing certain credentialing practices.”⁸ Although the public comment period has ended, the OIG has yet to issue guidance on this subject. The OIG has indicated that a proposed rule addressing this topic could be issued sometime this year. Many of the statements made by the OIG in the request for comments indicate the OIG’s initial reluctance to restrict economic credentialing practices. The OIG recognized the historical precedent that the denial of a physician’s hospital privileges was “rarely actionable” under anti-kickback laws.⁹ The OIG went on to note the proliferation of physician ownership in freestanding facilities, and stated, “These physicians may be in a position to steer profitable business or patients to their own competing business through their control of referrals. 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.”¹⁰ The OIG did, however, go on to state its concern that “discretionary decision-making” could raise certain anti-kickback risks.¹¹

Physicians also complain that such policies breach their contracts with hospitals because many conflict of interest credentialing policies do not provide for an appeal process prescribed by medical staff bylaws.

To date, hospitals have successfully defeated these physician challenges to the policies in the few cases addressing this topic. The primary argument in favor of a hospital’s right to adopt such policies derives from the same arguments used to defend the hospital’s right to enter into exclusive contracts, a practice which has been almost unanimously upheld by courts addressing exclusive contracting throughout the country.

The Florida case of Rosenblum v. Tallahassee Memorial Regional Medical Center, Inc.¹² is considered by many to be the first “pure” economic credentialing case to reach the courts.¹³ In Rosenblum, the plaintiff was a prominent physician who was denied clinical privileges in the field of heart surgery, in large part because of his contractual responsibilities as program chairman and developer of a competing program at the nearby Tallahassee Community Hospital.¹⁴ The court held that the defendant hospital was not arbitrary or capricious in its denial of medical privileges for economic reasons.¹⁵ Florida’s statutory regime was pivotal in the case, as the provision in controversy sets forth criteria to be used by governing boards in determining eligibility

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

⁹ Id. at 72,895.

¹⁰ Id.

¹¹ Id.

¹² Case No. 91-589 (Fla Cir. Ct. 1992).

¹³ See, e.g., RICHARD A. FEIDSTEIN, ECONOMIC CREDENTIALING AND EXCLUSIVE CONTRACTS, 9 HEALTH LAWYER 1, 5-6 (1996).

¹⁴ Id.

¹⁵ Id.

for staff privileges.¹⁶ The court stated the inclusion of the proviso “and [by] such other elements as may be determined by the governing board” validly embraced the concept of economic credentialing.¹⁷

The most prominent case addressing conflict of interest credentialing is the South Dakota case of Mahan v. Avera St. Lukes.¹⁸ Avera St. Lukes (“ASL”) is a nonprofit hospital located in the small South Dakota community of Aberdeen. After losing their neurosurgeon in 1996, ASL began recruiting replacements, only to discover qualified physicians were unwilling to relocate to Aberdeen if there were competing physicians practicing in the area, thereby diluting potential profits in the field.¹⁹ In response, ASL’s Board of Trustees passed two resolutions that in sum closed the medical staff with respect to certain spinal procedures, and closed staff membership to any new applicants for orthopedic surgery services.²⁰ A suit for an injunction was brought by a group of Aberdeen orthopedic surgeons who had opened a day surgery center in direct competition with ASL.²¹ Though ASL’s resolutions did not affect the privileges of the physician-members of the center, the group claimed ASL’s refusal to grant privileges to a physician subsequently recruited by the group resulted in an economic hardship for the physicians.²² On appeal from the trial court’s granting of an injunction in favor of the plaintiff-physicians, the state’s highest court stated ASL’s response “to the effect the [day surgery center] would have on the economic viability of ASL’s hospital and the health care needs of the entire Aberdeen community” was within its powers to ensure its economic survival, and “the courts should not interfere in the internal politics and decision making of a private, nonprofit hospital corporation when those decisions are made pursuant to its Corporate Bylaws.”²³ After comparing ASL’s actions to that of hospitals which choose to enter exclusive contracts for certain facilities, a practice it acknowledged to be almost universally valid and enforceable, the court stated it was illogical to argue ASL could not close its facilities to any new orthopedic surgeons in performing three identified procedures – what amounts to an implied exclusive contract with all current orthopedic spine surgeons.²⁴

In furtherance of the idea that conflict of interest policies are logical and legitimate in light of a hospital’s recognized right to enter into exclusive contracts, a Pennsylvania court held that when a physician leaves the employment of an exclusive contractor, the hospital is not required to renew the departing physician’s clinical privileges.²⁵ In Lyons v. Saint Vincent Health Center, the court recognized the right of the hospital to enter into such an exclusive arrangement for radiology services and held that to allow the physician to maintain clinical privileges outside the employment of the

¹⁶ See FLA. STAT. ch. 395.011(5).

¹⁷ Rosenblum, Case No. 91-589.

¹⁸ 621 N.W.2d 150 (S.D. 2001).

¹⁹ Id.

²⁰ Id. at 153.

²¹ Id.

²² Id. at 154.

²³ Id. at 156.

²⁴ Mahan, 621 N.W.2d at 159.

²⁵ Lyons v. Saint Vincent Health Ctr., No. 2369 C.D. 1989 (Pa. Commw. Ct. 1999).

contracting group would be to place that physician above the hospital's decision to enter into the contractual arrangement.²⁶

While these cases have dealt with decisions by hospitals to restrict access to its facilities to prospective physicians in light of increased competition in the marketplace, few have considered the implementation of conflict of interest policies that retroactively restrict current staff physicians. This issue will likely be determined in the near future as more states take up this issue for legal review. Currently in a California superior court, the medical staff of a local hospital has been granted standing to sue as an unincorporated association for what it perceives to be a stripping of its autonomy by the hospital's imposition of a code of conduct and conflict of interest policy, among other policy implementations.²⁷ According to one source, the policies required physicians to disclose participation in ventures that compete with the hospital and prevented physicians involved in competing ventures from serving on hospital committees.²⁸ Recent implementation of conflict of interest policies in Ohio could also lead to additional caselaw or a hospital's right to remove active staff members under such a policy.

V. WHAT IS THE FUTURE OF CONFLICT OF INTEREST CREDENTIALING?

Continued reductions in payments for healthcare will only increase the competition for these dollars. Shrinking dollars and increased competition will exacerbate the tension between hospitals and their medical staff. As physicians seek to increase their revenue through ownership in freestanding facilities and joint ventures with hospitals, they will invariably position themselves as competitors to hospitals. In some cases, hospitals will have no choice but to allow the physicians to compete against the hospital because using a conflict of interest credentialing policy would simply drive physicians to competing hospitals. In other markets, hospitals may be successful in using conflict of interest credentialing as a means of improving the hospital's strategic position and preserving its economic viability. Time will tell whether other state courts will uphold the use of conflict of interest credentialing. Even if this policy is allowed, it is unlikely that hospitals will use this strategy unless it has no other choice, because of the potential disputes it creates. Despite the use of conflict of interest credentialing policies, the continued growth of physician hospital joint ventures is likely as hospitals seek to use both "carrots" and "sticks" in working and competing with physicians.

²⁶ Id.

²⁷ See Med. Staff of Cmty. Mem'l v. Cmty. Mem'l Hosp., Case No. CIV219107 (Ca. Super. Ct. 2003).

²⁸ Mark Taylor, *Judge: Medical Staff Has Standing to Sue Hospital*, Modern Healthcare's Daily Dose, at http://www.modernhealthcare.com/dailydose/2003-08-08_dailydose.html#ts2 (Aug. 8, 2003) (last visited Jan. 9, 2004).

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The authors would like to thank Jennifer J. Hillard, a second-year law student at the University of South Carolina School of Law for her able assistance in providing research and analysis related to this article.