September 30, 2002

Mr. Kevin G. McAnaney, Esq.
Chief, Industry Guidance Board
Department of Health and Human Services
Office of Counsel to the Inspector General
Room 5527 Cohen Building
330 Independence Ave.
Washington, DC 20201-0001

Re: Exclusive Credentialing of Medical Staffs

Dear Mr. McAnaney:

In 1999, the American Medical Association (AMA) alerted June Gibbs Brown about the dangerous practice of "exclusive credentialing" of medical staff members. Since that time, we have received a number of reports from our membership indicating that an increasing number of hospitals are implementing exclusive credentialing policies across the country.

In response to these reports, the AMA has engaged Mark Rust of Barnes & Thornburg, a recognized legal authority on physician issues, to help us evaluate exclusive credentialing. Enclosed is a memorandum prepared by Barnes & Thornburg that updates and builds upon our 1999 letter. The AMA continues to believe that Office of Inspector General (OIG) clarification is necessary in order to reverse what is becoming a growing trend of exclusive credentialing.

Mark Rust and Rosary Payne of our Office of the General Counsel (312/464-4071) look forward to discussing this with you.

Sincerely,

Michael D. Maves, MD, MBA

Enclosure

cc: Rosary Payne
Mark Rust

BARNES & THORNBURG
MEMORANDUM

From: Barnes & Thornburg
To: American Medical Association
Re: Exclusive Credentialing
Date: September 25, 2002

This Memorandum will analyze and evaluate accounts recently made public and reported to the American Medical Association ("AMA") which demonstrate that hospitals are increasingly implementing policies that effectively prohibit physicians from referring patients to other entities upon fear of losing their medical staff membership or clinical privileges. The AMA alerted the Department of Health and Human Services ("HHS") and June Gibbs Brown of the issue of exclusive credentialing in a letter dated December 2, 1999, and requested a fraud alert to provide guidance to both physicians and hospitals. (letter attached hereto as Exhibit A). To date, HHS has not issued the requested guidance.

Exclusive credentialing violates the federal Medicare and Medicaid anti-kickback law, 42 U.S.C. 1320a-7b(b), in that prohibiting physicians from referring patients to competing institutions is indistinguishable from an affirmative requirement to make referrals. Furthermore, exclusive credentialing restricts a physician's ability to provide health care based on his or her professional judgment and the patient's needs and best interests. In essence, it is an anti-competitive business tactic that results in higher program costs and, potentially, lower quality patient care. Not only does exclusive credentialing significantly disadvantage hospitals that refuse to engage in what they correctly perceive to be criminal conduct, it undermines quality of care for patients. To protect these hospitals and patients, the OIG should take action to discourage or eliminate the practice of exclusive credentialing.

Exclusive Credentialing Defined

"Exclusive credentialing" refers to any policy adopted by a hospital that effectively requires physicians on staff to refer only to that hospital by prohibiting its staff physicians from referring to other facilities.[1] In our national health care practice, we have seen hospitals use various mechanisms to achieve this objective, while obfuscating their real intent. The mechanisms range from so-called "conflict of interest policies" to conditioning staff membership and privileges on a promise not to refer to competing facilities, to outright pronouncements from the hospital board of trustees forbidding staff physicians from relationships with new facilities. This practice has become increasingly common in such diverse places as Sharon, Pennsylvania, Columbus, Ohio and Lewiston, Maine.

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[1] Exclusive credentialing should be distinguished from "economic credentialing," which is more broadly defined as the use of any improper economic criteria unrelated to quality of medical care in any credentialing decisions. The AMA opposes the use of economic criteria not related to quality to determine an individual physician's qualifications for the granting or renewal of medical staff membership or privileges. (Res. 2, A-91; Reaffirmed: CME Rep. I-93-8; Reaffirmed by BOT Rep. 14, A-98). Although the motive for exclusive credentialing and economic credentialing is the same, exclusive credentialing results in criminal activity, while economic credentialing may not, in each case, be illegal under federal law.

In Sharon, Pennsylvania, one hospital system has adopted a "conflict of interest" policy that is an artfully worded restriction on physician referral patterns. Masquerading as a method to prevent "conflicts of interest" that "compromise the long-term viability" of the hospital, it is in fact a bald attempt by the dominant health system in the community to cut off the flow of referrals to its sole competitor, a smaller, struggling not-for-profit hospital.

Exhibit B is a copy of the policy; Exhibit C is a parsing and summary of the policy. It defines "conflict of interest" broadly to prohibit staff members and members of their group practices from having active medical staff membership or even serving in low-level leadership roles (such as vice-chair of the pharmacy committee) at competing facilities. These restrictions effectively require physicians to give up all but the most cursory affiliations with the health system's competitors.

In a more direct approach, the governing boards of two hospitals in Columbus, Ohio recently reacted to a plan by physicians to build an orthopedic hospital by passing resolutions that would deny or restrict staff privileges for physicians who invest in the specialty hospital. This action is presumably based on the hospital's fear that a physician who invests in a competing facility will refer solely to that facility, to the detriment of the hospital's bottom line. It ignores the quality care reasons physicians wish to facilitate more choices for patients, including consideration of cost, nurse-patient ratio, infection rates, and scheduling.

Anti-kickback Analysis

Exclusive credentialing is a transparent violation of the anti-kickback law. The anti-kickback law prohibits parties from knowingly and willfully offering, paying, soliciting or receiving remuneration with the intent to induce referrals for Medicare or Medicaid business. Because physicians with medical staff and clinical privileges refer to hospitals, the relationship between a hospital and a physician falls within the ambit of the anti-kickback law.

"Remuneration" under the anti-kickback law includes the transfer of anything of value, in cash or in kind. Medical staff and clinical privileges are a thing of value to physicians, as the ability to admit patients to a hospital is essential to most practice areas. Physicians on a medical staff routinely refer Medicare and Medicaid patients to the hospital. When a hospital effectively requires physicians to refer patients to it by prohibiting referrals to other facilities as a condition to granting or renewing privileges, it follows that the hospital is offering remuneration (privileges) with the intent to induce referrals. There is no safe harbor that protects this exchange of remuneration for referrals. It should not be seriously disputed that the main purpose of exclusive credentialing policies is to induce staff physicians to refer solely to the hospital.

HHS rules on analogous situations demonstrate the department's view that exclusive credentialing is problematic. The anti-kickback regulations prohibit hospitals from requiring physicians they recruit from engaging in exclusive credentialing.[2] The commentary to the recruitment safe harbor discusses a concern that hospitals may violate the anti-kickback law if they "prohibit the practitioner from obtaining or maintaining staff privileges at other facilities," condition recruitment payments on aggregate admissions, or require a recruited practitioner to admit a proportionate share of his or her patients to the recruiting hospital.[3]

HHS's rationale for limiting a hospital's ability to dictate a recruited physician's referral patterns in the recruitment safe harbor is equally applicable to exclusive credentialing of physicians who are not

[2] *See* 42 C.F.R. 1001.952(m).

[3] 64 Fed. Reg. 63543.

recruited. Conditions on privileges related to quality of care are allowed; conditions on privileges directly related to referrals create an illegal kickback.

Dangers of Exclusive Credentialing

Exclusive credentialing harms patients, federal healthcare programs, and the health care marketplace. Patients benefit when their physicians have staff privileges at multiple facilities, because the physician can select the facility that best suits the patient's needs from a cost, quality and convenience perspective.

Exclusive credentialing policies that prohibit physicians from referring to specialty hospitals or surgery centers, harm the federal healthcare programs by requiring that treatment be rendered in a more costly hospital setting. Exclusive credentialing also harms the health care marketplace in that it has a chilling effect on new development of surgery centers, specialty hospitals, or other innovations in health care delivery that have the potential to save the program money. Alternative facilities also can offer a higher quality of service than that offered by a hospital more intent on controlling physician referrals than on delivering the best personnel and technological support to its medical staff and patients.

Certain tax-exempt hospitals in Columbus and elsewhere have argued that restrictions on credentialing are necessary to preserve their ability to provide charity care. Hospital administrators worry that physicians will refer high-paying procedures to facilities that they own, leaving the low-pay or charity cases to the hospitals. This concern is a reaction to new economic realities in the health care marketplace dictated in large part by program reimbursement methodologies, which encourage a shift away from general acute care hospital services toward more efficient, less costly, and higher quality alternate settings. Rather than resorting to business tactics that are illegal under Medicare and Medicaid laws, hospitals should formulate a legal business solution to this perceived dilemma.[4]

Exclusive credentialing policies have also appeared in communities where there is no competing specialty hospital or surgery center. In those circumstances, hospitals with strong market share and revenue advantage (and thus the confidence to enforce such policies) have implemented these policies as a predatory practice to prevent referrals to competing acute care hospitals, ensuring a flow of referrals and endangering the viability of the sole competing (usually non-profit) hospital.

Conclusion

Exclusive credentialing is an unambiguous violation of the anti-kickback law. It is a method by which hospitals use economic mandates to compromise quality patient care. Physicians must be allowed to use their professional judgment when choosing a treatment setting for their patients. Hospitals should be encouraged to address economic realities in today's healthcare environment through innovation and fair competition, rather than by using internal economic factors to dictate how physicians practice medicine. Exclusive credentialing policies and practices are an attempt to undermine physician judgment, patient choice, as well as the viability of competing hospitals that act within the boundaries of the law. OIG clarification is necessary in order to reverse what is becoming a growing trend.

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[4] In addition to encouraging the use of alternate health care settings in program payment methodologies, HHS specifically recognizes and gives safe harbor protection to physician ownership of ambulatory surgery centers. *See* 42 C.F.R. 1001.951(r).