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Microhospital credentialing and privileging: Scale down without shirking industry standards

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Featuring a handful of inpatient beds and a narrow selection of community-tailored services, microhospitals are seeking to revolutionize care delivery in cities across the country.

These pint-sized purveyors of targeted interventions have a two-fold appeal: they present healthcare institutions with a low-risk vehicle for expanding or redefining their market presence and tout faster, more accessible care for patients in hubs where sluggish traffic, overcrowding, and limited building options can put traditional hospital services out of comfortable reach.

But despite the burgeoning care model's promise, its proliferation is outpacing the development of environment-specific regulations. Because microhospitals are currently regarded by CMS, accreditors, and many states as short-stay acute care hospitals, MSPs and medical

staff leaders must determine how best to rescale credentialing and privileging processes originally developed for large, full-service facilities.

"This is another example of the changes that are occurring in healthcare, and how the changes occur faster than we can figure out how to handle this from a credentialing and privileging standpoint," says **Kathy Matzka, CPMSM, CPCS, FMSP,** an independent medical staff consultant in Lebanon, Illinois. "Basically, what ends up happening is, the people who are the pioneers are blazing new ground, and everyone else is learning from them."

Among these trailblazers is CHRISTUS Southeast Texas Health System (SETX), a member system of the faith-based nonprofit behemoth CHRISTUS Health.

In April, SETX opened Outpatient Center Mid County, a 36,500-square-foot, $10 million facility whose services include imaging, lab testing, a women's center, outpatient therapy services, wound care, and round-the-clock emergency services. Despite its outpatient-centric name, the facility, which contains several inpatient beds, qualifies as a microhospital, according to **John A. Gillean, MD,** executive vice president and chief clinical officer at CHRISTUS Health. With two inpatient beds, the facility is licensed as a specialty hospital in Texas and regulated as an acute care hospital by CMS.

In January, SETX acquired a six-acre plot just south of the new facility, where it plans to build a second microhospital. The forthcoming facility's services, which are intended to complement those offered by the neighboring outpatient center, will include emergency, physician, and outpatient. Also like the center, the location will feature a limited number of inpatient beds and will transfer cases beyond its purview to SETX's St. Elizabeth campus, which is 15 miles away.

An uncertain term

Being at the forefront of a fast-moving trend can be a

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double-edged sword for microhospital operators, which get to differentiate themselves as care innovators but must pave the way with little formal guidance.

Another challenge, according to experts, is distinguishing microhospitals among the growing array of scaled-down, access-oriented healthcare models, which include established players like critical access hospitals (CAH) and ambulatory care centers, as well as newer models like freestanding EDs and urgent care clinics.

"It's a very unique animal," says **Patrick Horine, MHA,** CEO of hospital accreditor DNV GL's Business Assurance and Healthcare Accreditation Services. "It's not an ambulatory surgery center, it's not your typical acute care hospital, it certainly doesn't apply as a critical access hospital, so what is it?"

Part of the confusion stems from the descriptor's origins in the field and uneven application. "Microhospital" is an industry-coined term, not a formal regulatory or reimbursement designation—an important distinction, says **Lyndean Lenhoff Brick, JD,** president and CEO of Murer Consultants, a healthcare management consulting firm in Mokena, Illinois, that has guided client health systems, including SETX, through microhospital builds. "People may mean different things when they talk about microhospitals."

There are, however, some widely acknowledged commonalities, says Brick, most notably the model's "compact nature." Typically, microhospitals have fewer than 30 beds and offer a slim portfolio of lower-acuity services tailored to a specific community need. Common focuses include emergency services, psychiatry, women and children, and orthopedics, says Brick. Some facilities also offer selected ancillary support and outpatient services, such as imaging, dietary consultation, and therapy. When a case requires inpatient care, the length of stay is typically two or fewer days, Horine adds.

Given their scale, microhospitals also have much smaller ecological and economic footprints. Typically, they range in size from 15,000 to 75,000 square feet and, according to *Kansas City Business Journal*, cost $7 million to $30 million. They're also faster to build than larger hospitals, says Brick.

In terms of oversight, microhospitals are typically part of health systems, or offshoots of large independent hospitals, which grants them access to valuable resources they might not otherwise be able to afford, including, in many cases, a dedicated credentialing team.

The disciplines, specialties, and volume of practitioners tapped for microhospital practice depend on a facility's specific operational circumstances and chosen care focuses. In system-based varieties, practitioners typically have existing affiliations with the parent organization. They may, for example, be part of a contracted hospitalist or emergency services group that provides care at other locations.

Beyond microhospitals affiliated with a health system or large hospital, private operators may run freestanding chains of these facilities, says Brick. Stand-alone microhospitals are few and far between.

Benefits

Proponents of microhospitals cite their implications for organizational growth and patient care access.

"I see this as a very important addition to the continuum," says Brick, who believes the model can mitigate physician shortages by fast-tracking targeted care to patients with the most pressing needs. For example, psychiatric practices are shuttering across the country, unable to sustain efficient operations in large acute environments. For these providers, pivoting to a microhospital model can reduce steep overhead costs while accelerating development, opening the door for economical care delivery "to a population that desperately needs it," says Brick.

The model also presents tremendous opportunity for healthcare institutions that are trying to stay agile amid constant change in service delivery and payment methodologies.

"It's a low-cost care site alternative," says Matzka. "They can put up these small buildings and expand their market into an area, and it helps them to pull more patients."

Expert tips for opening shop and sustaining a successful operation

Because microhospitals are currently subject to regulations developed decades ago and with larger acute care institutions in mind, they can run into compliance obstacles that their traditional counterparts don't often encounter or are better equipped to handle. Here's a rundown of potential pitfalls and expert sidesteps.

Complying with EMTALA

Compared to a tertiary hospital, resources can be tight and clinical expertise narrowly concentrated in a scaled-down facility. "In the acute care setting, in most cases, you presume you're going to have a full-fledged medical staff and most of the ancillary support services to get you through whatever condition rolls in," says **John A. Gillean, MD,** executive vice president and chief clinical officer at CHRISTUS Health. The microhospital's "more limited scope" can leave staff scrambling to provide compliant care in unanticipated situations.

For example, microhospitals that offer emergency services are subject to EMTALA, a federal law requiring hospitals to stabilize and treat any patient who visits an ED, regardless of his or her insurance status and ability to pay, or the hospital's typical service focus.

For facilities with limited staffing and equipment, this requirement can prove especially burdensome, says Gillean, who urges organizations to ensure that their microhospital can handle patients with emergent needs beyond the facility's typical scope of service. During the planning process, account for high-risk scenarios that could play out in the real world, like a walk-in patient who's having a heart attack and requires immediate stabilization before he or she can be safely transferred to a tertiary hospital.

"You want to be able to have enough support services there so that you can manage that patient and truly stabilize them," says Gillean. "Think through the types of patients who might show up and what you would need to have available for that immediate scope of care to manage them and stabilize them before you transfer them."

Meeting basic patient needs

EMTALA readiness can also support compliance in other areas. When surveying microhospitals, accreditors will be particularly interested in the volume of cases treated on-site compared to the number that are routed to a partnering facility, says **Patrick Horine, MHA,** CEO of DNV GL's Business Assurance and Healthcare Accreditation Services. While their unique operational circumstances may translate to a higher transfer rate than typically seen in an acute care environment, microhospitals should have a clear intake strategy for assessing cases: distinguishing patients who are suited for on-site care from those who demand an intervention beyond the facility's scope, and, of course, stabilizing any patients designated for a transfer.

In addition to meeting patient needs associated with the primary condition being treated, microhospitals should be able to provide essential services, like nutritious food—an expectation that can be easier said than done for resource-strapped facilities.

"You certainly have the expectation that these hospitals can serve their patients while they're in the hospital, and with that limited number of admissions, it becomes a challenge," says Horine, recalling one facility whose application for DNV GL accreditation listed "the Ruby Tuesday across the street" as its food service. "What about therapeutic diets? What about consultation from a dietitian?"

While it's a safe bet that all inpatients will require food and water during their stay, some may also need ancillary services, such as clinical pharmacy, dietary consultation, and therapy. "It's not going to be every day that a patient needs rehab, but when they do, is the hospital able to provide that?" Horine asks.

Although there's no regulatory restriction on outsourcing such ancillary services, accreditors are more likely to scrutinize heavy reliance on this route for services provided routinely during the course of care, says Horine. Microhospitals should therefore limit contracting to services that the facility will need infrequently and provide everything else in house.

Communicating responsibly

While it's crucial to ensure the medical staff understands the microhospital's purpose and scope of service before opening, it's equally important to clue patients in. Fledgling specialty models, such as freestanding EDs, have come under fire for misleading or confusing billing practices.

For example, patients may mistake a privately owned emergency service provider for an in-network, hospital-based ED or a walk-in clinic where visits cost a fraction of a traditional ED stint. Meanwhile, the freestanding provider might only accept selected insurance (and even then at an out-of-network rate), landing unsuspecting patients with astronomical bills and, depending on their plan, little to no financial help.

To avoid such fallout, be transparent and up front with patients regarding your facility's purpose, billing practices, and accepted insurance plans, says Gillean. System-based microhospitals that operate under the same CMS certification number as a larger member facility can likely accept the same insurance plans as these partners, which could make them more attractive to cost-conscious consumers. For its part, CHRISTUS Southeast Texas Health System's outpatient facility accepts commercial and government plans.

SETX has experienced the model's promise for revenue growth and care access firsthand. In response to increasingly stiff competition from emerging healthcare providers in Southeast Texas, SETX, an established presence in the region, decided to build the outpatient center and forthcoming microhospital as satellite facilities of its two long-standing tertiary hospitals in the area, allowing the system to deliver targeted services in high-need areas, says Gillean.

Beyond meeting immediate community and market growth needs, construction of the satellite locations is part of an ambitious strategy SETX debuted in 2015 to "transform how health care is delivered" throughout Southeast Texas. The plan focuses on developing nontraditional, targeted healthcare facilities that align with patient utilization patterns. The system's 2014 research showed that 98% of its patients were treated on an outpatient basis. The strategy also mirrors the greater industry shift from inpatient to outpatient-centric care, the system noted in a press release. By 2020, SETX plans to grow its membership to more than 40 facilities across the region's nine counties, rolling out new urgent care centers, outpatient clinics, and primary care practices to supplement its 34 current locations.

The CAH comparison

Given their small scale and emphasis on care access, microhospitals might seem, at first glance, like the metropolitan equivalent of CAHs.

There are, however, some key differences. Beyond the obvious geographical divide—CAHs are based in rural communities—the models' service scopes also diverge, say Brick. A CAH functions as a general hospital for an underserved community. "So it's going to, by virtue of necessity, treat the heart attack and pneumonia and deliver the baby," says Brick. In contrast, microhospitals focus more narrowly on providing targeted clinical services to a specific segment of an urban or suburban patient population.

Additionally, and perhaps most significantly, "CAH" is a formal CMS designation for rural hospitals that meet specific criteria regarding operational circumstances, including:

- Number of beds (25 or fewer)
- Distance from another hospital (generally, more than 35 miles)
- Annual average length of stay (96 hours or less)
- Availability of emergency care services (24/7)

Qualifying facilities receive special Medicare benefits intended to improve their financial stability and their patient population's access to essential healthcare services. These perks include cost-based Medicare reimbursement, which can increase revenues; partnership with an acute care hospital that can lend support and accept transfers as needed; and CAH-specific Medicare *Conditions of Participation* (*CoP*), which are more flexible than their acute care counterparts.

In contrast, as an industry buzzword, "microhospital" doesn't have a standard definition, dedicated set of regulatory requirements, or distinct payment structure—at least not yet.

CMS has reached out to its contracted hospital accreditors for input on microhospitals, says Horine, who believes the agency is in the process of developing formal parameters for the proliferating model. But don't expect to see a custom definition take root any time soon, he warns. Promulgation would require congressional action.

In the meantime, a microhospital is considered an acute care hospital, albeit a compact one, and is subject to the same regulatory and accreditation requirements as any other facility in this category. "It has to operate functionally and legally and from a reimbursement standpoint as a hospital," says Brick.

Remembering this status is essential, especially as the spectrum of innovative healthcare models grows, and facilities with similar appeal but potentially different regulatory obligations gain ground.

"Trouble comes in if you take shortcuts that ignore the framework of the regulation," says Brick, pointing to loss of licensure, CMS certification, accreditation standing, and revenue as potential ramifications.

To avoid such fallout, microhospitals must comply with federal and state licensure laws for acute care hospitals, as well as with any standards necessary to achieve and maintain desired hospital accreditation.

Additionally, microhospitals that intend to bill Medicare and Medicaid (the vast majority, says Brick) must follow CMS' *CoPs* for acute care hospitals.

Achieving Medicare certification can be slow going, Horine says. CMS requires acute care hospitals to accumulate a certain number of patient records before even applying for the designation, and meeting this threshold can take a long time for facilities with low patient volumes. "I would love to advocate for a different type of system for handling that," says Horine. For example, an alternative measure might lower the initial case volume requirement for facilities of a certain size, but then impose a second threshold requiring certified providers to maintain a specific level of admissions, or stay below a certain volume of transfers, each year.

Surveyor guidance issued in early September may further complicate the certification process for microhospitals. In order to participate in the Medicare program as an acute care hospital, a facility must be "primarily engaged" in providing inpatient care, which, according to the new guidance, typically requires the provider to maintain an average daily census of two inpatients and a two-night average length of stay annually. The guidance fails, however, to specify how newly opened facilities without a 12-month track record would demonstrate their inpatient engagement, says **Sandra DiVarco, BSN, RN, JD,** an attorney with McDermott Will & Emery, LLP, in Chicago. "Does that mean new microhospitals need to wait to be certified?" she asks, calling such a delay "unnecessarily complex."

Beyond inpatient engagement, decisions regarding how to distribute CMS certification numbers (CCN) can dictate how surveyors evaluate system-based microhospitals.

"If they are licensed as a part of the system, and they are billing under the healthcare system's Medicare ID number, then they're just going to be surveyed as a part of the healthcare system the same way an outpatient physical therapy department or an outpatient ambulatory care facility or a long-term care facility that is associated with that healthcare system would be surveyed," says Matzka. In contrast, a microhospital with a distinct CCN would likely undergo a separate survey, even if the facility is affiliated with a larger hospital or a system, says Matzka.

State law is king

In the vein of CMS' broad definition for acute care providers, many states have a catch-all licensing category for hospitals, says Matzka, pointing to her home state as an example. "In Illinois, there's one set of hospital licensing regulations, and it applies to all hospitals regardless of whether you're an acute care hospital that has 1,000 beds or a critical access hospital with 15 beds."

Similarly, about a decade ago, Texas expanded its definition of a hospital in the licensing legislation to encompass ambulatory surgery centers that offer short-stay hospital services, says Gillean.

These legal definitions can have significant bearing on where and how microhospitals set up shop. Currently, Brick estimates that the model can be found in 20 states and expects this market penetration to grow in the coming years. That said, certain locales may accommodate the trend more readily than others.

"So much of it is, as you can imagine, state law–dependent," says DiVarco. "There are definitely states ... where this sort of concept may not go very far because there are restrictions on how many beds you're expected to have to have an acute care hospital."

Additionally, many states have certificate-of-need (CON) laws that can complicate, slow, or completely upend the microhospital development process. Intended to curb healthcare price inflation, CON programs require medical facilities to demonstrate that a proposed construction project would fulfill a community need before building. Currently, 36 states have

dedicated CON programs or close variations, according to the National Conference of State Legislatures.

Credentialing

The good news for MSPs is, once an organization has overcome any legal hurdles and opened its microhospital doors, credentialing practitioners for practice at the new location will likely have a minimal impact on the existing workload, says Matzka. "I don't see a big change as far as an MSP's job."

Of course, a microhospital's specific approaches to vetting, assessing competence, and governing the medical staff may vary depending on a number of operational circumstances. But a department dedicated exclusively to microhospital credentialing would be an unlikely sighting.

"It wouldn't be cost-effective," says Matzka. "They really don't have the volume to support a full-time or, in some cases, even a part-time credentialer."

Instead, she envisions most microhospital operators would implement approaches commonly seen among similarly situated CAHs. That is, freestanding entities would appoint an administrative staff member to take on credentialing as an additional responsibility or outsource the function to a commercial credentials verification organization (CVO), while system-based microhospitals would route the credentialing work to a larger member facility or a centralized department.

While credentialing plans have yet to be laid for SETX's forthcoming microhospital, the process will likely resemble the one in place at the new outpatient center, which shares a CCN and medical staff with St. Elizabeth and is therefore considered a department of the larger hospital. Under this structure, the outpatient center's practitioners are granted membership, credentialed, privileged, and assessed for competence through St. Elizabeth's established processes.

Organizations that opt to perform microhospital credentialing on-site should work smarter—not harder—to overcome resource limitations that might make compliance more arduous. "The trick is learning how to be efficient and expedient to meet those regulations," says Brick, who recommends cross-training staff on related functions. For example, credentialing may be performed by an HR director, an accreditation specialist, or a quality specialist. "They're going to have to wear many hats to make this economically viable." To improve the chances that cross-training will stick, be sure to hire competent staff with a high capacity for multi-tasking, Brick advises.

Microhospital-based credentialers can also look to their peers in the trenches for management tactics, such those in CAHs and other compact facilities that have decades of experience in running lean, efficient operations. "Cross-training is not really a new concept. It really is just an extension here in the microhospital of what's taken hold already in the healthcare industry," says Brick. "Rural hospitals have been doing this for generations."

Although most MSPs will find the microhospital credentialing process relatively straightforward, there is one notable consideration, says Brick.

When entering into a managed care contract specifying that the health plan will perform enrollment-related credentialing for microhospital practitioners, ensure the payer understands the facility's status as an acute care hospital and its obligation to meet all relevant requirements.

Sometimes, says Brick, health plans mistake microhospitals for a "glorified outpatient clinic," which might lead the payer to charge the microhospital a different rate or circumvent necessary credentialing steps.

Beyond promoting regulatory compliance, providing a clear description of the facility's mission and scope of services can help sell payers on a partnership. "A lot of payers like [the microhospital] because it's specialized care," Brick explains. "Oftentimes, that specialized care can help provide more efficient and cost-effective care."

Privileging

Whereas microhospitals generally "have their act together from the credentialing side of things," privileging practitioners for work in the setting can prove more challenging, says Horine, a sentiment echoed by

Matzka. That's because organizations must award privileges at the individual site level, regardless of whether they use an in-house or commercial CVO. "You're still looking to see whether they've got privileges and approvals of each individual hospital," says Horine. "Sometimes you see some things missing there," such as integration of sufficient performance data into the reappointment process.

When developing new privileging forms or adapting existing templates for the microhospital environment, make sure that outlined privileges only cover the services offered at the location. This is particularly important for practitioners who are seeking work in a system-based microhospital but who don't currently have privileges at another member location.

"Take a look at what's in the core, and determine whether or not these procedures are going to be performed at this facility," says Matzka. The form should not list "things that go above and beyond what kind of services are going to be provided."

Competence assessment

For many microhospitals, meeting accreditor-issued competence assessment requirements may be among the biggest compliance pain points, says Horine, citing the limited number of on-site practitioners available to participate in the process. For this reason, microhospitals without immediate access to appropriate expertise (e.g., through an affiliated facility or system) should consider external peer review. Regardless of whether they're able to find an in-house reviewer or are forced to look elsewhere, facilities must have a well-defined process for performing peer review.

Another common competence assessment challenge, particularly for unaffiliated microhospitals, is data capture, says Horine. Given their size and budget, certain facilities may have to forgo robust software that supports the successful management of performance data.

"You're looking at a less sophisticated type of system, so you depend more on the manual process for that, and you see a little bit of a disconnect that way as it relates to the performance data," he says.

Despite the inherent difficulties in maintaining paper-based processes, compliance and efficiency are within reach for organizations that build strong strategies to compensate for their limitations, says Horine.

"It doesn't mean that they can't do it, it's just that you have to have a better understanding of your processes and how that information is reported internally," says Horine. "What's your process for reappointment? How do you go about it given you lack this information that other hospitals have readily available?"

To promote performance improvement, he recommends measuring a mix of internal and external benchmarks that allow for comparison among practitioners and tracking of an individual's performance over time. "Sometimes that's lacking."

Though largely a sticking point in peer review, a microhospital's size does carry one potential advantage for the function. Compared to larger facilities with scads of data to sift through, microhospitals often have a better handle on identifying meaningful metrics, interpreting findings, and drawing objective conclusions, says Horine. This is because "you don't have as many physicians, and a lot of the data you're looking at has a direct impact on the doctors you have in place."

Medical staff governance

Organizations considering microhospitals as a way to kick-start their market growth must bring MSPs and medical staff leaders to the table early and often, according to Matzka and Gillean.

"The medical staff office needs to be involved in the planning phase so that they know what their responsibilities are as far as credentialing and privileging," says Matzka. Plus, insights from clinical leaders can help clarify the microhospital's mission, develop a viable service portfolio, and identify essential staff and resources, including those that promote regulatory and accreditation compliance, says Gillean.

Involving these key players in the planning process is particularly important for systems seeking to staff a microhospital with practitioners who don't have existing ties to the organization. In such cases, MSPs

and medical staff leaders would need to perform credentialing from scratch and develop a governance framework for this new faction of practitioners.

The chosen structure will depend on specific operational circumstances, including whether a system-based microhospital has its own CCN or bills under another system ID number. Generally speaking, however, Matzka says a unified medical staff makes sense for system-based facilities that will share geography and certain patient populations with larger member locations.

Beyond establishing a sound structure, microhospital operators must decide on the specific composition of their medical staff membership and leadership. Horine predicts the model will fuel the integration of advanced practice professionals (APP) into the medical staff fabric. This phenomenon has been steadily growing as organizations, especially CAHs, look to advanced practice registered nurses and physician assistants to alleviate the country's pervasive physician shortages, whose impact is greatest in underserved rural communities.

With these growing care gaps in mind, state legislators are increasingly relaxing laws regarding the medical staff's makeup. For APPs, this trend opens the door to new membership and leadership opportunities. For traditional medical staffs, it means determining how (if at all) to incorporate APPs into their historically physician-dominated ranks without sacrificing necessary clinical expertise, says Horine.

For example, CAH-based certified registered nurse anesthetists (CRNA) are often the most knowledgeable in the facility on anesthesia administration, but "does that mean they get recognized as part of the leadership for oversight of anesthesia services?" Horine asks. "A lot of that is going to be at the discretion of the medical staff, but, still, in light of some of the state laws changing and getting a bit more open in that way, I think you're going to see more challenges."

Where possible, he advocates a collaborative approach to governance. For example, grant an experienced on-site CRNA daily oversight of the facility's anesthesia services, but enlist an outside anesthesiologist to provide strategic and clinical guidance as needed.

Regardless of how medical staffs opt to resolve this issue, ensure the chosen approach aligns with all applicable state laws, Horine advises.

Bright future

Microhospitals are undoubtedly on the rise. "You're not finding those huge healthcare organizations popping up; it's going to be a smaller, more niche type of facility," says Horine. "Their claim is obviously satisfying a need in the community."

In the coming years, Brick expects microhospitals to grow in number, gain traction in additional states, and seek out new business partnerships. In particular, she predicts more alignment with accountable care organizations and direct contracting with large employers.

The model is already sparking innovative linkups. "Oftentimes health systems are even joint venturing with providers of services in various communities, which is not necessarily a partnership you would think of," says DiVarco. "But these models can result in financial and reputational advantages by increasing a system's footprint with less financial risk than a traditional hospital."

But even as healthcare continues to evolve at warp speed, and new care delivery models surface on what can seem like a daily basis, the principles underlying effective medical staff vetting, competence assessment, and governance are as steadfast as ever.

"In my mind, the credentialing standard of care extends beyond the numbers of beds that a facility has," says Matzka. "A hospital that has eight beds has to meet the same standard of care for evaluating competency of their practitioners as a hospital that has 1,000 beds."

Questions? Comments? Ideas?

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