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Wednesday, February 5th 2003

The Honorable Janet Rehnquist
Inspector General
Office of Inspector General
Department of Health and Human Services
Attention: OIG-71-N
Room 5246, Cohen Building
330 Independence Avenue, SW
Washington, DC 20201

Re: Development of Possible OIG Guidance Addressing the Legality of Certain Credentialing Practices under the Anti-Kickback Statute (OIG-71-N)

Dear Ms. Rehnquist:

On behalf of our nearly 5,000 member hospitals, health systems, networks, and other providers of care, the American Hospital Association (AHA) appreciates this opportunity to comment on the development of possible OIG guidance addressing the application of the Federal health care programs anti-kickback statute (42 U.S.C. § 1320a-7b(b)) (anti-kickback statute) to physician credentialing by hospitals.

The OIG notice acknowledges that the government has never viewed the granting of hospital staff privileges to physicians as "remuneration" under the anti-kickback law. This position has been and continues to be sound from both a legal and policy perspective. Staff privileges do not involve the transfer of something of value from the hospital to the physician, and the presence of managed care networks in a hospital's locale does not change this basic fact. After having examined and explicitly addressed hospital recruitment of physicians, neither Congress nor the Centers for Medicare and Medicaid Services (CMS) have treated privileges as remuneration under the Stark Law, thus confirming the propriety of the OIG's longstanding view.

Any attempt now to treat staff privileges as remuneration and regulate them accordingly would present near-impossible twin tasks: defining the exact market conditions under which staff privileges would be transformed into remuneration, and doing so in a way which makes industry compliance feasible, given that the market conditions at issue necessarily are fluid and may frequently change. Moreover, such an approach would immediately put every hospital and physician in violation of the Stark law, as well as create significant compliance burdens under the tax laws. In addition, any attempt by the OIG to regulate staff privileges would inappropriately interject the OIG into a process that of necessity should remain based on the hospital's mission of patient care, and its interest in ensuring efficient facility operations. Both

the law and practical as well as substantive policy considerations clearly argue against any change in the OIG's current position.

Hospital Staff Privileges are Not Remuneration

1. There is No Transfer of Any Benefit. Simply put, staff privileges do not involve the transfer of something of value from a hospital to a physician. This principle provides the legal basis for the historic distinction between staff privileges and those hospital-physician arrangements that the OIG has found may implicate the anti-kickback law. Hospital privileges simply constitute "permission to provide medical or other patient care services in the granting institution."1/ In granting privileges, therefore, a hospital transfers no cash or any equivalent in-kind benefit to the physician. Rather, to the extent a physician receives an economic benefit related to hospitalized patients, that benefit derives solely from the payment made by the physician's patient or his/her insurer for professional services rendered. There is no remuneration, in cash or in kind, from the hospital, which neither provides patient referrals nor performs the income-generating services. This is the critical distinction between privileges and those other arrangements which, after thoroughly examining hospital-physician relationships, the OIG has determined may constitute remuneration: special recruitment-related payments and benefits,2/ or free or discounted services or office space, below-interest loans, payments for medical education, and income guarantees.3/ The absence of any similar transfer of benefit in the privilege context has in the past exempted staffing privileges from the OIG's concern, and there is no legal basis for changing that analysis now.

2. The Managed Care Context Does Not Change the Legal Analysis. The OIG's request for comments asks whether the growth of managed care networks and local healthcare systems provides any basis for altering this long-held distinction between privileges and remuneration. It does not. Neither the growth of managed care plans, nor any other market development, transforms hospital staff privileging into remuneration. The reason is simple: access to patients covered by restrictive managed care plans is not a function of hospital staff credentialing, nor would any limitation on access be solved by expanding the definition of remuneration to include staff privileges.

In the situation of potential concern to the OIG, where a managed care plan covers a substantial portion of the patient population in a given locale, it is the managed care plan, not the hospital, that determines which physicians and hospitals will be included in its network and thus have access to plan patients. If a managed care plan limits its network to one hospital, it is the plan that is directly imposing this restriction on physicians and patients. Regardless of the hospital's credentialing requirements, and entirely independent of any credentialing criteria which OIG might view as "restrictive," the dictate that plan patients needing admission must be referred to a particular hospital comes from the plan. Accordingly, in this situation, any monetary value conferred on a physician by having access to managed care patients derives directly from the plan, and any restrictions on the physician's selection of a hospital for a patient who needs to be admitted also are imposed by the plan. Put another way, if a managed care plan dictates use of a particular hospital, it is the plan, not the hospital, which is dictating the terms of access to the patients, and any restrictive credentialing criteria imposed by the hospital will not burden a physician whose hospital referrals are in any event governed by plan rules. If the OIG is

concerned that access to patients by physicians and other providers, including hospitals, is being limited by managed care plans, the AHA respectfully suggests that defining remuneration to include hospital staff privileges would be neither an effective nor appropriate way to address those concerns.4/

3. Staffing Privileges Are Not Amenable To Regulation as Remuneration. Any change in the OIG's long-standing position on this subject necessarily would require the OIG to define with precision those parameters under which the granting of staffing privileges would (or would not) constitute remuneration. What is most striking in contemplating this task is the near impossibility of such an undertaking, which would require detailing all of the exact configurations of market conditions in a given locale (taking into account total patient population, number of managed care plans, number of patients covered by each plan, number and size of competing hospitals, configuration of managed plan networks, etc.) that the OIG believes would confer a monetary value on hospital staff privileges. Matching, if not surpassing the difficulty of that task, would be a hospital's ability to determine its compliance with those terms.5/

If, in recognition of these difficulties, the OIG instead were to issue guidance only generally describing the type of circumstances in which privileges could constitute remuneration, the result would be uncertainty and a chilling of legitimate credentialing decisions by hospitals. In this situation, not only the hospital, but also every physician seeking privileges, would be at risk of violating the anti-kickback law. Indeed, whether the approach is precise definition or general guidance, basing a determination of whether privileging is remuneration from a hospital to a doctor on circumstances wholly outside the control, and entirely independent of the intent, of either party would be an unfair and unreasonable interpretation of the law. This would be particularly problematic in light of the fact that the anti-kickback law is a criminal statute with severe sanctions (including imprisonment), and credentialing of physicians is essential to the operation of a hospital. These issues reinforce in a very practical way the legitimacy, as well as the regulatory necessity, of the OIG's long-standing view that privileges do not constitute remuneration.

4. Stark Law Implications. Any analysis of staff privileges as remuneration must also take into account the impact that such a position would have on enforcement activities under the Stark law. The Stark law (42 U.S.C. § 1395nn) defines prohibited compensation arrangements between a hospital and referring physicians as "any arrangement involving any remuneration between a physician" and a hospital. While the Stark law does contain multiple exceptions to this prohibition, none would apply to staff privileges. Under the Stark law and current regulations, therefore, a determination that staff privileges constitute remuneration would render as a violation of the law any referral to the hospital of a Medicare or Medicaid patient by a physician holding privileges, subjecting both hospital and physician to significant penalties if the hospital were to bill for services it furnished the patient as a result of the referral. The fact that neither the Congress nor CMS, the HHS agency responsible for issuing implementing regulations under the Stark law, found it necessary to create an exception covering staff privileges is highly relevant. Congress and CMS, like the OIG thus far, clearly have taken the view that staff privileges are distinguishable from those hospital benefits that are subject to the

Stark law - such as parking, internet access, and meals. The latter items constitute a tangible benefit of monetary value, and staff privileges simply do not.

In light of the Stark law's clear prohibitions, any change by the OIG to its (and Congress' and CMS') longstanding policy not to treat staff privileges as remuneration would undermine the legality of all existing staff relationships, and subject both physicians and hospitals to substantial penalties for violation of the Stark law. Should the OIG choose to change its position, therefore, such a change necessarily would have to be coordinated with congressional or administrative action to remedy this untenable outcome. 6/

Treatment of Privileges as Remuneration Would Improperly Interject the OIG Into Credentialing Decisions

A change in the OIG's long-standing position on this subject also would imprudently thrust the OIG into the middle of hospital decision-making about patient care and facility operation. Apart from all of the other considerations described above, it is critical that the OIG take into account the nature of the relationship between hospitals and physicians with staff privileges. A hospital must rely on its medical staff physicians as partners in the provision of care to patients. Indeed, in many ways, the quality and success of a hospital's operations are largely dependent upon its physicians. One of the most significant challenges facing community hospitals in meeting the needs of their communities is the growth of specialty care providers. Specialty care providers have the very real potential to siphon off from community hospitals the staff that are needed to provide care to every member of the community regardless of ability to pay, and the funds needed to support that care. Hospital policies that protect those vital community obligations from being undermined by the narrow economic interests of a specialty provider are both legitimate and appropriate. As the OIG recognizes, hospitals need to be able to preclude conflicts of interest, which could undermine the commitment of staff physicians to the welfare of the hospital.7/ Moreover, a hospital in a locale with a large supply of clinically qualified physicians should be free, within the bounds of antitrust law, to establish credentialing criteria which take into account the benefit to patient care and hospital operations of having a physician staff which is as integrated as possible into the daily routine of the hospital. It is for good reason, therefore, that the federal government has never viewed it as appropriate or wise to attempt using the anti-kickback law to interject itself into the staff privileges process.

In sum, there is no reasonable basis to deem hospital staff privileges to be remuneration under the anti-kickback law, and the Stark law's treatment of physician-hospital relationships indicates that Congress and CMS agree with the OIG's long-standing view on this point. Any limitation on physician access to patients which may have developed in conjunction with the growth of managed care is not created, nor will it be alleviated, by treating staff privileges as remuneration subject to the anti-kickback law. If managed care limitations on physician and provider access to patients is a problem, it should be addressed directly through appropriate regulation of managed care plan practices. For the OIG to attempt to expand the definition of remuneration to include hospital staff privileges and to subject staff credentialing activities to the severe potential penalties of the anti-kickback law is entirely unnecessary and inappropriate, as well as unworkable from a regulatory standpoint. Such an effort to regulate hospital-physician

relationships would be a harmful and legally unsupportable interpretation of the law, and would imprudently interject the OIG into a hospital's decision-making process.

We thank you for this opportunity to express our views. If you have any questions about this matter, you may contact me or Maureen Mudron, Washington Counsel, at 202-626-2301, e-mail: mmudron@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President

1/ Joint Comm'n on Accreditation of Healthcare Orgs., Comprehensive Accreditation Manual For Hospitals GL-5 (Update 3, August 1999).

2/ See 42 C.F.R. § 1001.952(n)

3/ See OIG Special Fraud Alert, 59 Fed. Reg. 65372, 65376 (December 19, 1994), available at http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html (originally issued May 1992).

4/ The analysis would be the same in other market situations where circumstances beyond the hospital's control limit hospital access, such as in a region served by only one hospital.

5/ For example, even assuming, for purposes of argument, that every hospital has a reasonable means of determining whether managed care penetration and activity in a particular locale would make privileges remunerative, this determination would have to be updated on a continuing basis as the market changes and new privileges requests are addressed. Moreover, as market conditions change, credentialing criteria that may have been legally applied to some physicians, may not be permitted to be applied to other physicians on the same medical staff. These problems and anomalies inevitably would further chill legitimate credentialing activities.

6/ Similar problems would arise in the tax context where, if privileges constitute remuneration, not-for-profit hospitals would have to value privileges and demonstrate receipt of service of equal value from key members of their physician staff in order not to be subject to intermediate sanctions under the Taxpayer Bill of Rights statute. In addition, all hospitals and non-employee physicians would face the prospect of having to value and report (on 1099s and personal tax returns) this "remuneration" as income - an incredibly burdensome nightmare of a task.

7/ See 67 Fed. Reg. 72,894, 72,895 (Dec. 9, 2002).