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January 17, 2003

Office of the Inspector General  
Department of Health and Human Services  
Attention OIG-71-N, Room 5246  
Cohen Building  
330 Independence Avenue, Southwest  
Washington, DC 20201

Re: Economic Credentialing

Dear Madam/Sir,

I am writing in response to your request published in the Federal Register on December 9, 2002, for comments regarding a variety of "economic credentialing" behaviors. By way of background I have worked for almost thirty (30) years with medical staffs on their bylaws and other issues pertaining to their implementation of their delegated authority from the board of the hospital to surveil and maintain the quality of care rendered by their peers, other clinicians and others within the hospital environment. I have also served on the board of the National Committee for Quality Assurance (NCQA) for eleven (11) years and just stepped down after five (5) terms as Chairman. I continue as a board member.

Set forth below are my observations regarding why certain practices which fall under the label "economic credentialing" violate the anti-kickback statute. I begin with an overview of the role and scope of proper medical staff credentialing. I then discuss the economic implications to credentialing. I address each of the questions posed in the request for comments. I describe seven practices I have seen in my representation of physicians and medical staffs which implicate the statute and I explain why.

Role and Scope of Credentialing

The board of directors of the hospital has the fiduciary responsibility to steward the hospital's resources and assure the quality of care provided by the institution. The care provided by the institution turns, above all, on the behavior of the physicians on the medical staff who utilize the hospital's resources to provide care to their patients. The hospital has no business to manage or operate without the actions of the physicians who by law are licensed to order the services the hospital provides. These otherwise typically independent clinicians come together in common cause only around their use of the hospital's resources.

In order to fulfill the obligation to assure quality, the typical lay board of trustees must safeguard and surveil the quality of services the institution provides through and as a result of physician behavior. Typically the board does not have within its membership the expertise and technical knowledge to do so and therefore must rely on the input and recommendations of the physicians. For the physicians to conduct this delegated, advisory authority effectively, they must organize into a medical staff which provides structured recommendations to the board for the board's ultimate determination as to which physicians will be permitted to use the hospital's resources (membership) and in connection with the delivery of what services (privileges).

The totality of the mechanisms by which this permission is granted, and removed when the medical staff member fails to measure up to the hospital's standards, are set forth in the medical staff bylaws which the board approves. These processes are often referred to under the rubric of "credentialing". Technically credentialing is the process by which the applicant for staff membership or reappointment is evaluated with respect to his qualifications. Credentialing literally means an evaluation of the physician's credentials – licensure, board certification, DEA registration. Privileging is the determination of which specific delineated procedures and skills he will be permitted to exercise in the hospital.

These relationships are recognized in law in (1) the Medicare Conditions of Participation, (2) the Joint Commission on Accreditation of Healthcare Organization (JCAHO) Standards which have legal significance by virtue of the process by which a hospital can be deemed to meet the Medicare conditions based on JCAHO accreditation as well as in (3) state hospital licensing regulations. The gravamen of the interaction between the medical staff and the board, and the bedrock basis for exercising this authority, as stated by all authorities, is the quality of care the physicians will and do render within the institution. Whether all staff members are board certified, required response times in case of emergency, whether members must take emergency on-call coverage duties and the prerogatives and obligations of different categories of medical staff membership are typically the fundamental judgments to be made by the medical staff and approved by the board to establish baseline criteria for the granting of medical staff membership. These decisions establish the culture of the medical staff and the clinical culture of the hospital. There are differences among hospitals on these bases that can be quite legitimate. (See, Gosfield, "Defining Institutional Culture: The Role of Medical Staff Bylaws in Hospitals and HMOs," in Gosfield ed. 1992 HEALTH LAW HANDBOOK, Clark Boardman Callaghan, New York pp. 299-326; and Gosfield, Quality and Clinical Culture: The Critical Role of Physicians in Accountable Health Care Organizations, American Medical Association, 1998, <http://www.ama-assn.org/pub/category/8340.htm>)

That medical staff membership decisions might be made in ways that improperly take into account considerations unrelated to quality has arisen before. In 1974 I was engaged by the Commonwealth of Pennsylvania to provide a comprehensive redrafting of their hospital licensure regulations. At that time, managed care was a nascent organizational approach to health care. When physicians who were participating with managed care organizations sought membership on medical staffs, they were sometimes discriminated against because the hospitals they applied to and the medical staff members evaluating their credentials saw these managed

care organizations as communistic or otherwise threatening. In response, the Commonwealth adopted the following regulation which remains in effect today:

*No applicant shall be denied medical staff privileges on the basis of sex, race, creed, color, national origin or on the basis of any other criterion lacking professional or ethical justification, including association with a prepaid group practice. (Emphasis added, 28 Pa. Code § 107.3(c)).*

Other types of inappropriate considerations have also been addressed by the courts. In the case of Berberian v. Lancaster Osteopathic Hospital, 395 Pa 257, 149 A2d. 456(1959) it is not widely known that the real issue behind this case of first impression, establishing that the relationship between the board and the medical staff members is one of contract, arose where Dr. Berberian was targeted by the medical staff because he performed abortions. The way in which the termination of membership decision was implemented, he alleged, was in contravention of the hospital medical staff bylaws from a procedural perspective. That inappropriate judgments may come into play in credentialing is clear.

That the relationship between a medical staff member and the hospital has economic implications is undeniable. The physician renders services at the hospital for which he will bill the professional component and be paid. The right to act within the hospital is an opportunity to provide services which have direct economic value to him. Case law abounds with respect to the nature of the harm suffered by physicians who are precluded from exercising their clinical privileges within the hospital. Physicians denied membership or privileges sue alleging antitrust and civil rights violations, violations of their procedural rights and other legal theories to redress their economic injury from the denial or restriction imposed. These cases demonstrate that the ability to exercise medical staff privileges has economic value to physicians.

That the medical staff has economic value to the hospital by virtue of their referrals to the institution and their ordering of services within the institution is also obvious. It has already been recognized under the Stark statute which includes among the designated health services for which referrals are implicated, those for inpatient and outpatient hospital services, even though the definition of "referral" purports to be limited to services paid for under Part B, which hospital services are not. (See, 42 USC §1395nn (h) (5) (A))

There is no question that a hospital as a business entity seeks "heads on the beds"; in other words, to function as a business entity, the hospital needs the physicians to use its resources. Consequently, the fundamental relationship between a physician member of the medical staff and the hospital is imbued from both sides of the transaction with economic value. The question at hand is whether the granting of or restrictions upon the granting of medical staff membership or privileges for reasons unrelated to the quality or clinical competence of a physician would implicate the anti-kickback statute.

The ability to serve as a medical staff officer, as the chair of the department, or as a member of the hospital board also has economic value but in a slightly different way. The officers of the medical staff and the department chairs acquire an aura of prestige which can translate into economic value to the physician in terms of referrals and other business generation. Moreover, many department chairs are compensated for the time they spend in administration on behalf of the hospital. Clearly there is direct monetary value associated with access to those positions. With respect to medical staff leadership positions, the prestige of the officer status encourages other referrals from physicians in the medical staff and has longer term economic value to them on that basis. The membership on the board of the hospital is the least of these activities directly implicating monetary or economic value; but increased status in the community is always useful for physicians. These aspects of economic credentialing do not implicate the statute in quite the same way, although they are certainly used by the hospital as a way of discriminating among physicians and in some instances based upon their anticipated referrals. For example, as indicated below I have recently seen the elected vice chair of a department within a medical staff organization denied the ability to assume such role because of his refusal to sign a financial relationship disclosure form.

#### Remuneration in Kind

The anti-kickback statute is phenomenally broad in its sweep. The terms of this statute implicate “remuneration . . . in kind”. Barely addressed in any of the case law, this term calls into question hospital practices to induce the referral of federally funded patients or in reward for ordering or arranging for the provision of a federally paid for service, item or good by a hospital where there is a remuneration in kind to the referral source. Remuneration in kind means to provide a non-cash economic benefit in payment for something. Here, the non-cash economic benefit is the privilege to use the hospital’s resources, for which the physician will generate his own compensation, in exchange for anticipated referrals. As elaborated more fully below, where a hospital discriminates in its selection of physicians for membership based upon economic considerations, and as a result husbands the “franchises” available to utilize the hospital’s resources based upon the hospital’s expectations of referrals from the physicians to whom it gives privileges (and denies privileges to those from whom they fear that they will not get enough referrals) it is hard to understand how this would not implicate the statute.

The denial of membership is a denial of an economic benefit to the physician. The granting of membership is an economic benefit to the hospital based around the continued utilization of its resources by those whom it would select based upon the expected referrals. It is, in fact, the use of these discriminatory practices which implicates the statute. The exclusion of some clinicians purely on the basis of their expected economic value to the institution and awarding of an economic benefit to those who are seen as likely to provide more referrals to the institution would seem on its face violative of the statute. This is directly analogous to the concern the OIG has already stated on offering investment interests or more favorable investment terms to physicians in a joint venture who are expected to provide more referrals than others.

### Appropriate Discriminations

There is a truly legitimate quality issue associated with the volume of services that certain critical physicians will perform in the hospital. As a quality policy analyst for many years, I know that over and over again, those concerned with quality have learned that the best way to assure good outcomes, particularly for high risk surgical procedures, is for a hospital to have the opportunity to do many of them, repetitiously, involving the same teams of practitioners, -- nurses, physicians, operating room technicians -- who are used to dealing with each other in a team context. This is the premise behind the Leapfrog Group's recommendation of evidence based hospital referral. It is entirely appropriate for a hospital to determine that for certain critical services it will only award clinical privileges to those physicians who perform a sufficient volume of procedures there to assure them that (1) not only will the team approach to quality be provided, but also (2) that the number of procedures performed is sufficient to be able to effectively monitor the physicians' quality over time, and thereby enhances the capacity of the hospital resources to meet the needs of patients seeking these specific services. Even before the current era, this type of discrimination in hospital privileging has been upheld where a surgeon was denied privileges because his multiple memberships elsewhere would preclude his effective contribution to the hospital's teaching mission. (Robinson v. McGovern, 521 F. Supp. 842 (DC. PA., 1981).

Similarly, it is entirely legitimate for the hospital to require that a sufficient volume of procedures is performed by a staff member in the institution over time to be able to have sufficient data to make appropriate quality judgments. To do otherwise may impede substantive quality. Moreover, to do otherwise and be assured that clinical competence is present, the hospital would have to seek quality relevant data about the practitioner from other institutions. Then there is no guarantee the requisite clinical information will be made available, since the other institution will have its own constraints on sharing patient and/or peer review data.

### Questions Posed in the Federal Register Inquiry

In the request for comments, a number of questions were posed. Let me turn my attention to those:

A. Hospital staff privileges are a remuneration in kind when they are offered in exchange for agreements to refer. By precluding certain benefits to physicians who do not engage in such implied obligations, the fact that the remuneration in kind is both given and demanded becomes clear. Where financial relationships with competitive facilities are the basis for the discrimination, the essence of the competition is the anticipated referrals the competing entity will get, which the privilege-granting hospital will lose. The advent of channeled referrals to specific healthcare institutions under managed care networks only increases the economic value of the franchise of obtaining medical staff privileges. The fact of the scope or characteristics of the market is essentially irrelevant to the violative nature of the demand. The physician's ability to utilize services at a hospital which is convenient to his patients, or has resources that

otherwise might not be available, has real economic value to him by providing the ability for him to bill a professional component for these services. That opportunity translates directly into monetary value. Because physicians provide their own services in the hospital and may only do so by virtue of medical staff membership, that membership (and concomitant privileges) is a clear economic benefit. Consequently, the hospital allowing the economic benefit only in exchange for the ongoing referrals is the fundamental problem.

B. A hospital's denial of privileges to a physician who has a relationship with an entity which competes with the hospital is a tacit demand for referrals. It is particularly troublesome when one considers that the physicians who are in a position to have their own competitive resources, whether by ownership or by contract, are generally well established, well financed groups who have usually gotten there by virtue of their good quality and reputation in the community. In fact, if a hospital were truly motivated by concerns for quality of care, one would think that these would be the very individuals they would most want actively involved as members and as medical staff leaders. The current approach of hospitals in restricting access to their resources, in ways that preclude what they deem competitive smacks both of a spurned lover's response as well as cutting off their noses to spite their faces.

Given the value to the hospital of granting privileges broadly, to deny physicians access based on fears of some referrals going elsewhere, makes little business sense. Where a hospital directly employs a physician, as would be the case with any other employer, requiring restricted referrals would not implicate the statute since there is a specific exception for any amount paid by an employer to an employee pursuant to a bona fide employment contract. If the privileges are remuneration in kind, then they represent a form of compensation to the employee which would be exempted under the statute. In addition, a very small minority of hospitals have closed staffs, meaning that all the members of the medical staff are employees of a separate professional corporation. While this approach does not manifest a direct employment relationship with the indicia of the master-servant, the strategic decision to have a closed medical staff requiring employment with a third party is more analogous to a direct employment relationship and, to my mind, does not implicate the statute. Rather, the primary implication of the statute as appropriately noted in the original inquiry turns on the discrimination that takes place among otherwise independent economic actors in the community.

A further question is raised with respect to differences that might be appropriate given the distinctions among mere staff membership, a medical staff leadership position, or membership on the board of directors of the hospital. It should be noted that the JCAHO specifies in its standards that (1) "The medical staff has the right to representation (through attendance and voice), by one or more medical staff members selected by the medical staff, at governing body meetings." (GO.2.2.1) (2) "Medical staff members are eligible for full membership in the hospital's governing body, unless legally prohibited." (GO.2.2.2) Any physician sitting on the board of the hospital as a member would, obviously, have to meet general corporate standards of fiduciary responsibility to the

organization. There is no justifiable basis to distinguish these board members from their colleagues. The other board members are not restricted with regard to their business practices outside of the organization in terms of practicing medicine, investing in healthcare enterprise, having other healthcare financial relationships or referring patients to other institutions. Whether the right to be invested in conflicting businesses is part of the board's conflict of interest policies should be uniformly applied without any discrimination regarding the medical staff members of the board as distinct from any other members of the board.

With respect to medical staff leadership positions, unless the individual is a department chair directly contracted as an employee by the hospital, the right of the hospital to control an independent economic actor's investment, financial relationships and referral relationships by virtue of obtaining medical staff leadership is absurd. Assuring the physician's ability to dedicate time to the role as the department chair would be appropriate. Requiring appropriate dedication of time to fulfilling medical staff officer functions would also be appropriate. Business confidentiality requirements are certainly appropriate since a well functioning Medical Staff Executive Committee (MSEC), for example, would obtain sensitive information regarding the strategic plans of the hospital. These plans should be treated with strong confidentiality requirements. However, referrals and utilization of other facilities, or investment in other facilities is completely irrelevant to the ability to exercise these responsibilities appropriately.

In medical staff membership decisions, the economic behaviors of the medical staff members outside of the walls of the hospital ought to be of no concern to the hospital with respect to privileging decisions. The arguments made by hospital advocates that they need the hospitals' resources utilized to remain viable is unassailable. However, the requirement that the physicians refer to the institution for reasons other than maintenance of quality in exchange for the physician getting access to the economic benefit of being able to bill for services at that institution by using its resources violates the statute.

C. The question is raised in the request for comments as to whether the exercise of discretion by the privilege-granting hospital affects the analysis under the anti-kickback statute. As noted above, it is the discrimination among the otherwise eligible physicians based purely on their expected referrals which is the crux of the violative economic credentialing. I would concur that discretionary decision-making of this kind raises significant risk under the anti-kickback statute. Whether on the initial application or later, determination as to whether referrals can be expected and the preclusion of medical staff leadership or membership on the basis of referrals or outside economic activities flies in the face of the anti-kickback statute.

To allow as unchallenged these kinds of economic practices also calls into question other polices already enunciated by the Office of the Inspector General (OIG). For example, for virtually the entire history of the anti-kickback statute it has been improper for hospital based physicians to be commanded to provide free services, to buy

hospital services at inflated rates, to make contribution to hospitals in cash and or otherwise to give items or services of value in order to obtain the ability to render exclusively contracted services. The exact same analysis pertains to the opportunity to exercise clinical privileges within the institution.

D. The question is raised as to whether privileges could ever be conditioned on referrals. As noted above, where the physician is the direct employee of the hospital or the hospital has a closed medical staff, these requirements are legitimate under the anti-kickback statute. However, the hospital's failing health should motivate the hospital to want as many physicians as possible utilizing its services rather than to preclude services to some in favor of others. In the same way that there is no distinction between a kickback of \$1.00 and a kickback of \$10,000, there is no distinction between a requirement of 25% of referrals compared to 75% of referrals. Any requirement of referrals for any reason other than quality based judgments would be inappropriate under the anti-kickback statute because of the economic value of clinical privileges to the physician and the commensurate economic value to the hospital of the anticipated referrals.

E. With respect to clinical privileging which turns on group practices, the relationship between hospital medical staff membership, which is a citizenship concept, and clinical privileges, which is a clinical concept, is made on the basis of the individual involved. As a matter of fact, both the Medicare Conditions of Participation and the JCAHO hospital accreditation standards make it clear that "decisions on appointments or granting of clinical privileges must consider criteria that are directly related to the quality of care." (MS.5.4.5) In addition, "appointment or re-appointment to the medical staff is not granted solely on the basis of an applicant's membership on the medical staff of another hospital." (JCAHO 2001 Standards, P. 282) The evaluation of clinical privileges and membership turn on hospital specific criteria and must reflect quality. The decisions have typically been made for individuals. The membership relationship has traditionally been focused around individuals. While privileging decisions could be group practice focused as a way to propel quality (See, Gosfield, "Whither Medical Staffs?: Rethinking the Role of the Staff in the New Quality Era," 2003 HEALTH LAW HANDBOOK (in press)), to evaluate the financial relationships of an applicant's group practice colleagues is no different from the assessment of the applicant alone. The only reason to inquire about such relationships would be an expectation that the applicant would refer to his partner's economic partners. The inquiry is still about hoped for referrals which might go elsewhere.

Now let me turn to economic credentialing practices I have encountered and how I believe they implicate the statute.

### Types of Practices

In my practice alone (and I suspect that there are even more unusual versions of these types of problems) I have encountered essentially seven different types of economic credentialing practices.

Issue 1. Hospital required completion of a highly detailed disclosure, not only of ownership, but any other financial relationship with any other healthcare institutions, extending the inquiry not only to its own board members but to mere applicants for membership on the medical staff and those seeking reappointment. Failure to complete these forms, which may require reference to information that is subject to confidentiality clauses under other arrangements, has been used to deny medical staff leadership positions to clients of mine for no reason other than refusal to complete the form. These disclosures have also extended to members of the applicants' or staff members' families.

Implications: There is no justifiable reason associated with quality for a healthcare enterprise ownership relationship to be disclosed in applying for medical staff membership or privileges or medical staff leadership functions. Moreover, there is no appropriate basis associated with quality mandates for the hospital to investigate any other financial relationships of physicians with any other organizations and particularly there is no reason to inquire as to these matters as they relate to family members. There is nothing associated with financial relationships with other institutions, or in the ownership of any other health care enterprise, which could have competitive implications to the inquiring facility. The ownership is not what the fear is about. The fear of lost referrals is the sole basis for these inquiries. It is the discriminatory exclusions that I would characterize as a direct admission against interest that the primary concern in these disclosures is to preclude physicians from an economic benefit because of their unwillingness to guarantee referrals to the hospital.

Arguably one might make the case that for a physician to be a member of the board of directors he would have to act in a fiduciary capacity with respect to the hospital on whose board he sits. The mere fact of investment, however, has no bearing on his capacity to function as a fiduciary. It is the investment combined with the referrals that is truly at issue here. For a physician to buy shares of stock that are publicly traded in a healthcare enterprise to be disclosed in these documents is utterly irrelevant to the capacity of the physician to function as a fiduciary on a hospital board.

With respect to medical staff leadership, the physicians elect their leaders for reasons that reflect the concerns they have with the respect to the capacity to be represented in the medical staff organization. Again, investment in other organizations would be irrelevant. Other financial relationships are already constrained by the anti-kickback statute and Stark statute to the extent that physicians would be inappropriately induced by their financial relationship. Consequently, to inquire further about these relationships is, again, purely for the purpose of determining whether there is a risk of

“losing” referrals that would otherwise come to the inquiring hospital. Since the only reason to obtain the disclosure is to determine whether it would implicate potential referrals, the mere fact of the inquiry is suspect under the anti-kickback statute.

Issue 2. Preclusion of membership, leadership positions or board of director roles for those medical staff members or applicants who have “competitive” investments whether in other hospitals, ambulatory surgery centers or imaging centers.

Implications: The actual preclusion of membership, leadership or board membership to those with competitive investments and financial relationship is even more strongly violative of the anti-kickback statute. To restrict the availability of these positions that have economic value to the physicians on the basis of the anticipated benefit that they will bring to the hospital in the form of referrals would on its face appear to be the demand for a remuneration in kind for access to the applied for position. To the same extent that the statute would preclude demanding discounts, concessions, and free services in exchange for an exclusive contract, these preclusions are directly analogous.

Issue 3. Medical staff bylaws requiring the member of the staff to dedicate a percentage of his/her practice to the hospital in order to maintain membership and/or leadership positions.

Implications: Dedication of a percentage of the practice to the hospital in order to obtain membership or leadership is likely unenforceable. How would a hospital determine the scope of the practice whose referrals they are garnering? Nonetheless, the point of these efforts is to preclude the economic value of medical staff membership and leadership to those who are not referring sufficiently to the institution. Again, this would appear on its face to violate the statute. On the other hand, requiring as a condition of specific delineated privileges that physicians provide within the institution a specified threshold number of specific procedures, as determined by applicable specialty boards and societies as appropriate to maintain skills, would not be problematic under the statute.

Issue 4. Loyalty oaths combined with rights of first refusal. I have had clients requested to sign documents indicating that they will not sell their practices, they are not contemplating doing so, nor merging, nor investing in a potential healthcare investment without providing the hospital with, in essence, a “right of first refusal” to participate in any such ventures. This approach has been used for physician members of the hospital board as well as medical staff leadership positions.

Implications: Loyalty oaths are but a precursor to a disclosure of ownership. Combining them with rights of first refusal, in other words, that the physicians as economic actors may not freely contract in the marketplace without bringing in the hospital, is intended to preclude the types of relationships about which the hospital is likely concerned under numbers 1 and 2. This approach takes the fact of medical staff membership and converts it into still a further type of economic opportunity for the

hospital which is inappropriate when linked with access to privileges. Conditioning membership, medical staff leadership or board membership on much restricted economic behavior is yet another demand for remuneration in kind in exchange for the desired franchise, be it membership, medical staff leadership or board position.

Issue 5. Requiring physicians who are otherwise being considered for the right to read echocardiograms under contract to the hospital in the heart station to refrain from providing any echocardiogram services in their own private practices.

Implications: To condition the cardiologists' opportunity to render services in the heart station pursuant to an exclusive contract on their agreement to forego providing these services in the physicians' office would appear to be in violation of the statute on its face, not to mention a direct increase to the cost of the Medicare program. Obviously, it is more expensive to provide these services in the hospital environment than in a physician office environment. In addition, it is often more convenient to provide these services in a physician's office. To condition the ability to obtain such an exclusive contract on the foregoing of the provision of a full panoply of services to the physician's patients would fly in the face of the statute.

Issue 6. Hospitals looking at their relationship with physicians employed by another system taking the position that the other system itself must enter into a direct contractual relationship with the first hospital with respect to the way the physician member of the medical staff at the hospital which does not employ the physician will engage in otherwise potentially competitive activities.

Implications: To require the physician's employer (another hospital system) to enter into a contractual relationship with the inquiring hospital as a condition of medical staff membership I have seen only once. I found it to be patently absurd but that did not stop the hospital from asking for it. This would also appear to require the physician's employer, with whom the hospital has no privity of contract otherwise, to control the physician employee to the same extent as the hospital would desire to do it directly as indicated above. For all the reasons indicated above, these demands would appear to violate the statute.

Issue 7. Business confidentiality policies imposed on members of the board of directors, the medical staff leadership and mere members of the medical staff. This is the one practice among those that I am addressing here which does not implicate the anti-kickback statute, as far as I am concerned.

Conclusion

There is no question that physicians have become more active in their pursuit of additional opportunities to generate revenue based upon their economic relationships with healthcare enterprises. Hospitals may, indeed, feel that the enterprises in which the physicians are involved are a threat by virtue of competing with them. Particularly for a tax exempt hospital to condition membership and clinical privileges on tacit agreements to refer would appear to violate the statute. Rather, hospitals competing with other healthcare enterprises ought to be doing so on the basis of their convenience, the quality of their services, their responsiveness to the concerns of physicians and their excellent management. Extorting referrals from physicians by virtue of discriminatory practices in this manner undermines the public value of the hospital, denies broad access of services to the local community, and frankly seems directly counter-intuitive to the desire of the hospital to have its resources utilized maximally. The awarding of membership and privileges should turn on quality concerns. To allow economic credentialing would also call into question virtually all of the other pronouncements the Office of the Inspector General has made to date with respect to non-cash remuneration in exchange for referrals.

If you would like to see copies of any of the materials cited in the letter, or the disclosure documents and other policies my clients have confronted please do not hesitate to let me know. If I can elaborate on any of the points made here, please do not hesitate to let me know.

Sincerely yours,

Alice G. Gosfield

AGG/ss