

WHITE PAPER

Hospital Sponsorship of Physician Participation in The Physician Leadership Institute of Iowa

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This White Paper summarizes the compliance issues associated with a hospital's payment of some or all of the cost of a physician's participation in The Physician Leadership Institute of Iowa ("PLI"). This White Paper is intended as a general statement of applicable compliance principles associated with hospital payment for its physician leaders to attend and participate in PLI. It is not intended as legal advice to any individual hospital. The application of these principles to individual hospitals and their physicians is highly fact-specific, and hospitals are encouraged to review the matter with their legal counsel before proceeding.

Background on PLI. PLI is a cooperative effort of the Iowa Hospital Association ("IHA") and the University of South Florida College of Medicine. The program materials describe PLI as a rigorous twelve-month leadership development program delivered on site at seven locations throughout Iowa. The target audience is described as "physician leaders (CMO's, VPMA's, Chairs, Chiefs of Staff, Medical Directors, etc.) and physicians who have leadership potential." The program materials further state that by investing in their physicians, healthcare organizations will realize a competitive advantage through a changing health care environment and achieving physician engagement over the long term, and that ultimately, organizations will create a pool of the next generation of physicians destined to lead healthcare transformation. While some of the curriculum is broadly oriented toward creating physician leaders generally, it seems clear that the focus is towards physician leadership in a hospital environment.

Hospitals have an interest in developing strong physician leaders within their organizations, both for administrative and medical staff roles. Thus, hospitals may desire to sponsor physicians for PLI. This can occur in the context of several different hospital relationships with physicians. In some cases the physician may be employed by the hospital, in other cases the physician may be in private practice but currently contracted to provide a physician leadership service to the hospital, and in other cases the physician may have leadership potential but no current employment or contractual relationship with the hospital.

Consistent with the extensive curriculum, the cost of PLI is significant (in excess of \$10,000 per participating physician). In addition, physicians will be expected to participate in regular activities, both at one of the central classroom sites or in their communities, and thus will be absent from their medical practices during such time and incur travel and other incidental expenses. Finally, we understand that physicians will be eligible to receive CME credit for their participation in PLI.

Analysis.

1. Compliance Issues – Stark. We believe that the primary compliance issue is under the Federal Ethics in Patient Referrals Act (generally known as the “Stark” law). Under Stark, a hospital cannot bill or collect from Medicare for any services ordered or referred by a physician who has a financial relationship with the hospital, unless such financial relationship falls into one of the exceptions under the statute. The first issue here is whether there is a financial relationship at all. A financial relationship is defined broadly to include any relationship in which anything of value is transferred between the parties. When a hospital provides education and training to a physician relative to a physician’s performance of an administrative service to the hospital, it can be argued that there generally is no compensation relationship established with the physician.

The American Medical Association and CMS have previously engaged in correspondence about the ability of a hospital to sponsor and pay for CME programs for physicians. AMA in a letter dated May 6, 2005 advocated for a broad Stark exception for CME programs and suggested standards that might be included in such an exception. CMS responded on March 13, 2006 declining to create such an exception, but noting that “traditional, on-site hospital grand rounds and other similar in-house education programs provided by hospitals are important and convenient ways for physicians to earn CME credit and for hospitals to ensure high quality patient care. We do not believe that such programs, which historically have been provided on-site at no charge, necessarily constitute remuneration to the physicians who attend them.” CMS indicated an intent to further address this in public comments in an upcoming final Stark rule. AMA then sent a letter CMS dated December 19, 2007 responding to the final Stark rule expressing concern whether hospitals can still rely on the CMS comments from the March 13, 2006 letter and advocating that hospital-based CME programs do not create any risk of abuse. CMS responded in a letter dated May 6, 2008. It provides further clarification and seems to set out several guiding principles:

- a. On-site CME is not remuneration if it is provided primarily for the benefit of the hospital's patients (e.g., training on prevention of nosocomial infections).
- b. CME that is not primarily for the benefit of the hospital's patients is considered remuneration.
- c. When there is remuneration, one of the exceptions might apply: non-monetary compensation (up to \$300 as adjusted for inflation) or medical staff

incidental benefits (up to \$25 as adjusted for inflation). CME for employed physicians also probably falls within the employment exception.

d. Programs that provide compliance training as their primary purpose are permitted.

e. Where CME constitutes remuneration and where an exception cannot be met, physicians should bear the cost.

Here, we believe it is significant that the target of such training is present and future physician leaders within the hospital organization and that PLI appears focused on helping hospitals develop effective physician leaders. This focus makes it unlikely that physicians would pay for PLI themselves, since they would likely perceive that it benefits the hospital.

Generally, we believe that hospitals could sponsor and pay for employed physicians for PLI to the extent it facilitates their performance of their job duties for the hospital. For existing contracted physicians, the hospital would need to establish the relationship of PLI to their carrying out of their contractual duties. Paying for a physician currently in a leadership role is a stronger case than for one who might serve in such a position in the future. As to physicians not currently employed or contracted, the burden on the hospital is greater since the physician is not currently performing any duties for the hospital. Some evidence of the hospital's desire to engage the physician to perform services in the future coupled with some evidence of the physician's willingness to do so seems important.

Because of the potential that hospital sponsorship could be viewed as a financial relationship under Stark in the case of non-employed physicians, a written agreement with the physician relative to his or her participation in PLI is advisable. The agreement (which could be in the form a mutually signed business letter) should set forth the expectations for PLI participation and a commitment to utilize the tools learned through participation in hospital leadership positions.

2. Compliance Issues – Anti-kickback. The anti-kickback statute prohibits provision of anything of value, directly or indirectly, in cash or in kind, with the intent to induce referral of patients. The statute is an intent-based statute, but the courts have held that if “a” purpose of an arrangement is to induce such referrals, then the statute has been violated. Safe harbors have been promulgated under this statute, but all of the relevant safe harbors tie back to a fair market value concept. Here, the initial question is whether the physician has been provided with something of value without paying any consideration for it.

The Office of Inspector General has issued a special fraud alert describing hospital incentives to physicians and suspect arrangements that it would analyze. The list includes several examples of arrangements in which the hospital provides something of value (office space or equipment; billing, nursing, or other staff services; training of physician office staff; or payment of a physician's travel and expenses for conferences). The OIG has taken the position that providing something of value without fair market value consideration raises a

presumption that an illegal intent exists, because there would presumably be no other reason to provide services to a referral source at less than fair market value.

The anti-kickback issues are limited to non-employed physicians, since relationships with employed physicians are broadly protected under the statutory exception and regulatory safe harbor. However, with non-employed physicians, the analysis is similar to that of Stark, with the need to show a strong relationship between the participation in PLI and the physician's duties to the hospital. It is also important here that participation (and any physician portion of cost) not be adjusted based on volume or value of expected or actual referrals and that physicians not be selected based on their ability to make or influence referrals. Again, a written agreement documenting such hospital benefit is advisable.

3. Compliance Issues – Tax Exemption/Public Body. For hospitals organized as nonprofit corporations exempt under Section 501(c)(3), tax-exemption issues are also important. A tax-exempt hospital is subject to two general restrictions. Under the first, the earnings of the Hospital cannot inure to the benefit of private individuals. This rule generally is limited to individuals who are classified as insiders with respect to the hospital. The second component requires that any expenditure of funds be primarily for a public purpose, and that any benefit to private individuals be incidental, both qualitatively and quantitatively, to the accomplishment of such public charitable purposes. Here, the concern is that paying for a physician to attend PLI confers a "private benefit" on the physician which is inconsistent with the Hospital's tax exemption. Again, it is necessary to show the connection between the PLI sponsorship and the physician's duties to the hospital.

Federal regulations at 26 CFR 53-4958-1 *et. seq.*, impose intermediate sanctions on any excess benefit transactions entered into by tax-exempt organizations and disqualified persons. Disqualified persons include a variety of individuals who would be in a position to exercise influence over an exempt organization. We believe it is likely that some of the physicians being sponsored for PLI would be treated as disqualified persons. The excise taxes are imposed on any transactions for which the benefit to the disqualified person is greater than fair market value. In addition, the failure to treat and report compensation as taxable income to the physician can result in an automatic excess benefit, which results in an excise tax on the physician and on "organization managers" who participate in the transaction knowing it to be an excess benefit, unless such participation was not willful and was due to reasonable cause. It could be argued that an excess benefit is being conferred if there is not a sufficient connection between the hospital's payment of PLI participation fees and the physician's duties to the hospital.

For hospitals organized as public governmental hospitals under Iowa law, compliance with public body constitutional limitations are important. Article III, Section 31 of the Constitution of the State of Iowa prohibits public money being used for private purposes. While several judicial decisions note that the concept of public purpose is to be interpreted broadly and is a flexible and broad concept, they all note the importance of this Constitutional restriction. Several Iowa Attorney General Opinions have addressed this issue. For example, in Iowa Attorney General Opinion 90-7-3 (July 3, 1990), the Attorney

General opined that the payment of service club dues by a public body could only be made if the membership in that public body relates directly to the employee's job and thus serves a public purpose. That principle would seem to apply equally here.

For all hospitals, there are also tax issues relative to potential reporting of income to a physician. If the hospital pays for participation and such participation is not tied back to specific hospital duties, the hospital payment could be viewed as taxable income to the physician. In addition, any incidental expenses reimbursed by the hospital should follow IRS accountable plan rules in order to avoid taxable income to the employed physician. These same principles apply to payments made to or on behalf of independent contractors.

Summary. In summary, the ability of a hospital to sponsor physicians for PLI is a highly fact-specific analysis, tied to the identifiable benefits to the hospital of the individual physician's participation. For employed physicians with a leadership role or potential, the analysis parallels that applicable to any other conference or CME program. It also requires attention to potential taxable benefits if expense reimbursement related to PLI participation does not follow IRS accountable plan rules. For non-employed physicians, the analysis is more difficult because of the need to more specifically tie the PLI participation back to some discernable benefit to the hospital. In such cases, hospitals should consider a formal process for approval (preferably at a board or a board committee) that documents the benefits to the hospital and an agreement with the physician committing to PLI participation and to utilizing skills learned from PLI in ongoing services to the hospital. The stronger case here is for physicians who currently serve in hospital leadership roles or who have been elected or appointed to do so. Expense reimbursements must also follow accountable plan rules.

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