

Health Law ADVISORY

Current legal insights for health care executives

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Medical Staff Funds – What Rules Apply?

We have had questions from two clients recently about proposed expenditures from “medical staff funds.” Both expenditures would raise compliance concerns under Stark if made by the hospital. The initial question in each case was – are medical staff funds hospital funds? The equally important question that emerged was – what are the unintended ramifications if they are not?

In the first case, the hospital had a contract to pay its independent chief of staff a small stipend each year, and the medical staff kicked in half of the amount. Seven months into the term, the medical staff wished to increase the compensation and was willing to pay in the entire difference. Under Stark, the hospital’s arrangement to pay the chief of staff a stipend in the first place could fit within either the fair market value compensation exception or the personal services exception if all conditions are satisfied. However, *both* exceptions require that compensation for the same services not change during the first full year. Thus the hospital could not increase the stipend out of its own funds during the year. Could the medical staff pay the difference and thereby insulate the hospital from Stark consequences?

In the second scenario, a medical staff wished to expend funds to arrange for off-site (but local) CME opportunities for members of the staff. Under Stark, a hospital is limited in making payments for the benefit of its independent staff physicians for their personal CME. The applicable exception is for “non-monetary compensation.” A hospital is permitted to provide non-monetary items and services (not including cash or cash equivalents) that do not exceed \$300 per calendar year, adjusted for inflation (approximately \$330 at this time). In this case, the benefit per physician would exceed the \$330 per physician lid. Could the medical staff pay it, even if the hospital could not?

Under Stark, if a physician has a financial relationship with a hospital (or other billing entity) that does not fit an exception, the hospital is prohibited from billing for any designated health services, such as hospital inpatient and outpatient services that are referred by the physician and payable in whole or in part under Medicare. In both scenarios the compliance issue is whether expenditures from medical staff funds are really expenditures of hospital funds. If so, the way in which those funds are spent would probably be attributed to the hospital. It would be as if the hospital

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made the same expenditure.

When confronted with these issues, there are two questions to be asked. First, are the medical staff and its funds really separate, so that medical staff expenditures are not viewed as hospital expenditures? Medical staffs always think so. However, in almost every case the medical staff account is owned and reported under an EIN issued to the hospital. In many of these cases the money is accounted for by the hospital on its 990. It is hard to argue that the money is not hospital money, even if the hospital has granted the medical staff discretion in spending it, and even if the money is entirely attributable to medical staff dues. When a hospital determines that the account is held under an EIN of the hospital, it must consider whether medical staff expenditures have Stark implications for the hospital.

The second question is – if the funds are held under a separate EIN, what are the ramifications? There are several important potential answers:

1. First, an EIN must be held by a taxpayer. An organized medical staff, without corporate, LLP, or other formal “form” is probably an “unincorporated association” under state corporation law. Medical staffs certainly can be organized in this fashion. Once they are so organized, they have their own taxpayer reporting obligations. The medical staff needs to know what they are to know what their obligations are.
2. Second, individual members of an unincorporated association are typically liable individually for the negligent acts and omissions of the association. An unincorporated association operates like a partnership. Thus, if a claim can credibly be made against the separate

medical staff organization for breach of the peer review sections of the bylaws, for example, individual members of the medical staff could be jointly and severally liable in damages. Very few clients wish to be organized as an unincorporated association when the liability ramifications are explained. And, the activities of an organized medical staff, with particular reference to peer review, utilization management, investigations, and quality initiatives all do carry potential liability to third parties.

3. Third, adverse peer review decisions are often attacked on antitrust grounds. Section 1 of the Sherman Act prohibits a contract, combination, or conspiracy in restraint of trade. As the terms suggest, there must be “two or more parties” to have a contract, combination, or conspiracy. An entity cannot “conspire with itself.” When a medical staff is viewed as an organizational component of the hospital, courts typically view the staff’s actions as the acts of the hospital. They are all part of the same entity, and do not support a Section 1 attack on the decision.¹

There may be solutions to allow hospitals and medical staffs in these examples to accomplish their objectives. The key, however, is to recognize the relationships for what they are in order to know which rules to apply.

The lesson – hospitals should know what expenditures the medical staff is making from “medical staff funds” and satisfy themselves that the expenditures will not create Stark issues for the hospital.

Alex M. (Kelly) Clarke

... are the medical staff and its funds really separate, so that medical staff expenditures are not viewed as hospital expenditures?

¹ Note: this does not mean that individual members of a medical staff exercising staff responsibility cannot be challenged if they misuse their peer review authority in order to harm a competitor or harm a peer out of malice.

Compliance Accreditation News

- The Centers for Medicare and Medicaid (CMS) has revised the “incident to” rule as it is applied to outpatient hospital departments. On June 19, 2008, CMS included this modification to the Medicare Benefit Policy Manual in the July 2008 Update of the Hospital Outpatient Prospective Payment System. The revision removes language stating that services furnished in provider-based departments of hospital must be rendered under the direct supervision of the physician *who is treating the patient*. This requirement has been operationally troublesome, particularly in the case of provider-based specialty clinics, since it was announced in February 2007 (Medicare Transmittal 82). Transmittal 82 was also an issue because it conflicted with 42 C.F.R. § 410.27(f) which permitted *any physician* immediately available in an emergency to supervise outpatient services in a hospital.
- The July 1, 2009 implementation of Joint Commission Hospital Standard MS.1.20 has been suspended by The Joint Commission Board. This action was the result of work by a Task Force appointed by the Board to study MS.1.20 due to the extent of criticism and objections raised to it by accredited hospitals. Further word is expected in August 2008 when the Task Force is also expected to propose revisions to MS.1.20. Any proposed changes are likely to be circulated in draft form for “field review” by accredited hospitals. Hospitals may wish to delay Medical

Staff Bylaws’ revisions in this regard until the final standards are known.

- What’s on the horizon for the Stark Law now that Stark III has been issued? CMS sources have indicated that are likely to be more clarifying rules by January 2009 addressing unresolved items from the 2007 Physician Fee Schedule: “stand in the shoes” application to academic medical centers and integrated 501(c)(3) health care systems and anti-mark-up provisions other than anatomic pathology diagnostic testing services. Also, it is expected that CMS will soon issue more Stark Advisory Opinions and FAQs.

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Questions? Ideas?

We welcome your questions, ideas and suggestions.

E-mail jknutson@bairdholm.com and help make the Advisory interactive!

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