Hospitals & Health Systems Rx

Gifts and Incidental Benefits to Medical Staff Physicians

Asha B. Scielzo, Esquire*
Jones Day
Washington, D.C.
Gerald M. Griffith, Esquire**
Jones Day
Chicago, Illinois
Travis F. Jackson, Esquire***
Jones Day
Columbus, Ohio

I. Introduction

Gifts, complimentary items, and other incidental benefits and business courtesies such as free parking, meals, continuing medical education (CME), entertainment, and courtesy discounts provided by hospitals to their medical staff physicians have long been sources of concern for regulators. Simply put, anything of value directly or indirectly provided to a physician (or their family members and office staff) may implicate the federal law prohibiting certain referrals by physicians, 42 U.S.C. § 1395nn (the Stark Law) and the federal anti-kickback statute, 42 U.S.C. § 1320a-7b(b) (the Anti-Kickback Statute), and equivalent state laws. Hospitals organized under Section 501(c)(3) of the Internal Revenue Code of 1986 (the Code) are also subject to certain restrictions and reporting obligations in connection with such gifts and incidental benefits (the Tax Requirements).

It is likely that every hospital is offering some form of free items, gifts, or other business courtesies to their medical staff physicians (e.g., bagels in the doctor's lounge, CME classes, sports, or cultural event tickets). Accordingly, if a centralized process or consistently applied policy is not implemented, it is likely that Stark Law-mandated thresholds are being exceeded and Anti-Kickback Statute and tax risk is greater than the hospital's legal or compliance department may realize. As part of an effective compliance program, every hospital should develop a policy for compliance with these laws, to include a process for tracking the provision of gifts, complimentary items, and other incidental benefits provided to physicians (and their immediate family members and office staff).

This article provides an overview of applicable laws as they relate to the provision of free items, gifts, and incidental benefits to medical staff physicians, along with recommendations for developing and implementing a policy and mechanism for tracking the provision of such items.[1]

II. Summary of Applicable Laws

A. The Stark Law

Under the Stark Law, if a physician has a financial relationship with a hospital, the physician may not refer patients to that hospital for the furnishing of "designated health services" (DHS) for which payment may be made under the Medicare or Medicaid program, and the entity may not submit claims to Medicare or Medicaid for DHS provided pursuant to a prohibited referral, unless a Stark Law exception applies.[2] The Stark Law applies to several categories of DHS, including inpatient and outpatient hospital services. A "financial relationship" is de-fined to include "compensation arrangements," which are the focus of the analysis here.

Generally speaking, a hospital's provision of gifts and incidental benefits to medical staff physicians constitutes remuneration to the physicians (i.e., something of value) under the Stark Law, which results in a "compensation arrangement." As such, any referrals those physicians make to the hospital for DHS (e.g., inpatient and outpatient hospital services) reimbursable by Medicare or Medicaid are prohibited under the Stark Law, unless all of the elements of an exception are met. There are several exceptions of potential relevance here; namely, the "non-monetary compensation up to $300" exception, "medical staff incidental benefits" exception, and the "compliance training" exception.[3] The "academic medical center" (or AMC) exception may also be relevant in certain circumstances where faculty physicians constitute a majority of the medical staff. Furthermore, to the extent remuneration is provided to a physician in exchange for such physician's provision of an item or service to the hospital directly or indirectly (such as service on a committee or as a medical staff officer), the "employment" exception, "personal services" exception, "fair market value" exception, and "indirect compensation" exception may be relevant, depending on the specific circumstances. Finally, if a hospital provides remuneration to physicians in the form of a courtesy discount, the "professional courtesy" exception may be relevant.

The two exceptions that were specifically designed to cover gifts to physicians each have specific dollar amount limits. The "medical staff incidental benefits" exception is limited to $25 (indexed for inflation to $28 in 2007) per gift with no aggregate limit in any year; however, these gifts must be offered to the entire medical staff or all physicians in the same specialty, must be reasonably related to the delivery of medical services at the hospital, and, with limited exceptions, must be used on campus during periods when the physician is making rounds or providing other services for the hospital or patients. The "non-monetary compensation less than $300" exception has no per gift limitation but is limited to $300 per year (indexed for inflation to $329 in 2007) regardless of what department within the hospital provides the gifts. The gifts under this exception also may not be solicited by the physician, the group practice, or other members or employees.

It is also noteworthy that those two exceptions have a number of common requirements: (a) the amount of the gift cannot be determined in a manner that takes into account the volume or value of referrals; (b) the gift must not violate the Anti-Kickback Statute; and (c) cash and cash equivalents are strictly prohibited, as are gifts or free items offered to group practices (e.g., medical equipment), even if the thresholds are not exceeded in the aggregate. The Stark Law regulations do not define the term "cash equivalents." Therefore, absent guidance from the Centers for Medicare

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and Medicaid Services (CMS), there is some uncertainty for Stark Law purposes as to whether gift cards or gift certificates that are not redeemable for cash and may be used only for a single specific item or service (e.g., gift certificate for a free Thanksgiving turkey redeemable only at a specific store by the individual named on the gift certificate) or a very limited range of specific items or services (e.g., redeemable for any of the daily specials at a local restaurant) would be viewed as "cash equivalents" for Stark Law purposes.

B. The Anti-Kickback Statute

The Anti-Kickback Statute prohibits offering, paying, soliciting, or receiving any remuneration, directly or indirectly, covertly or overtly, in cash or in kind, for (a) the referral of patients, or arranging for the referral of patients, for the provision of items or services for which payment may be made under governmental healthcare programs; or (b) the purchase, lease, or order, or arranging for the purchase, lease, or order, of any good, facility, service or item for which payment may be made under governmental healthcare programs.

Because the Anti-Kickback Statute is subject to expansive interpretation, the Office of Inspector General of the Department of Health and Human Services (the OIG) promulgated the "safe harbor regulations." To fit within any safe harbor, the arrangement must meet all of its criteria. The failure of an arrangement to fit within a safe harbor, however, does not necessarily mean that the arrangement violates the statute. Rather, a fact-specific analysis would be necessary to determine whether an activity that did not fit precisely within the prescribed safe harbors would be defensible under the Anti-Kickback Statute.

Analysis of whether an Anti-Kickback Statute violation has occurred involves two foundational questions. First, is "remuneration" involved? There is a violation only if "any remuneration" has been solicited, received, offered or paid. Second, if re-muneration is involved, is it "in return for" or "to induce" (or reward) a referral of an individual for, or arranging for, the furnishing of items or services for which payment may be made under a federal or state healthcare program? With regard to the first element–that "remuneration" has been solicited, offered, paid, or received–"remuneration" has been broadly construed to include virtually anything of value. Here, physicians are receiving something of value in the form of free items, gifts, and incidental benefits (even if some of these are of nominal value). The second element of the Anti-Kickback Statute is that remuneration must be "in return for" or "to induce" (or reward) a referral of an individual for the furnishing of items or services for which payment may be made under a governmental healthcare program. Significantly, the second element under the Anti-Kickback Statute requires a showing of intent. Many courts have held that even though a specific transaction may be motivated by numerous legitimate business purposes, if one of the purposes was to induce the referral of Medicare or Medicaid business, then the Anti-Kickback Statute is violated.[4]

In most cases, the Anti-Kickback Statute safe harbors will not apply to the provision of free items, gifts, and other business courtesies and incidental benefits. Furthermore, there is no "de minimis" exception under the Anti-Kickback Statute. In effect, any level of compensation or benefit conferred on a referral source entails a risk of violation of the Anti-Kickback Statute if the facts and circumstances would show that the item or gift is intended to influence the referral decision-making process or reward past referrals. Although there are no bright line tests in this area, there is some industry guidance of relevance such as the American Medical Association's ethical opinion on "Gifts to Physicians from Industry," along with industry guidance in the pharmaceutical and medical device industries, which although not directly on point, still offer useful insight on how the overall industry is dealing with physician gifts. Further, based on examples found in OIG fraud alerts and other letters, incentives that are more likely to be considered suspect by the OIG are payments made or gifts given each time a physician refers or at the end of a "good referral year"; free or significantly discounted equipment; free or significantly discounted billing, nursing, or other staff services; free training for office staff (including coding); payment of travel and expenses for conferences; payment for CME; inappropriately low-cost group health coverage; free chart review; free fax machines; and free biopsy needles.

Ultimately, in analyzing the risk associated with these practices, it is important to consider the purpose of the business courtesy or remuneration. The analysis is best thought of as a "risk continuum," with some practices carrying greater risk, while others entail less risk. Generally speaking, items of modest value that have a legitimate purpose such as education or improving service or quality would likely entail less risk under the Anti-Kickback Statute than gifts or incidental benefits that are of higher monetary value and are solely for the personal use or benefit of the potential referral source or their family members, practices, or other businesses.

C. Tax Requirements

In general, to maintain 501(c)(3) status, no part of the net earnings of the organization may inure to the benefit of any insiders (such as paying more than fair market value), and any benefit to private parties cannot be more than incidental (i.e., indirect and insubstantial in amount). The rationale for these limitations is that, since tax-exempt organizations are subsidized by taxpayers, this subsidy should not benefit private parties. From a reporting perspective, a tax-exempt hospital must report (on Form 1099 for non-employed physicians and Form W-2 for employed physicians) any item or gift that is included in a physician's "gross income" if the total fair market value of the benefits that the physician receives

directly from the hospital during the year is at least $600.[5] Even if the hospital would not need to report the item or gift on a Form 1099-MISC or W-2, the Internal Revenue Service (IRS) may require the hospital to disclose the benefits provided to physicians on its Form 990.

"Gross income" for federal tax purposes generally includes all economic benefits that an individual receives, except for those benefits that the Code specifically excludes. The Code excludes two categories of benefits from "gross income" that may be particularly relevant for free items and services that a hospital provides to physicians—working condition fringe benefits and de minimis fringe benefits.[6] "Working condition fringe benefits" are items or services that, if the physician paid for them directly, he or she could deduct the payments as an ordinary and necessary business expense. "De minimis fringe benefits," on the other hand, are items or services of low value (less than $100) that are provided to physicians so infrequently as to make accounting for them unreasonable or administratively impracticable (e.g., a holiday turkey likely fits this description but gift certificates likely do not). It is possible that a particular physician may receive an otherwise de minimis fringe benefit with such frequency that it is no longer de minimis to that physician. For example, if a hospital regularly provides a particular physician with free golf outings that are each valued at less than $100, the IRS would likely find that the benefit to the physician is not de minimis, even though the free golf outings may be infrequently provided to other physicians. If the benefit does not fall into one of these two categories, the hospital would generally need to report it as gross income to the physician on a Form 1099-MISC or W-2. However, if the total value of the items and services includible in gross income that the physician receives from the hospital is less than $600, the hospital would have no Form 1099-MISC or W-2 reporting obligation.

Form 990 requires tax-exempt hospitals to report certain benefits that it provides to employees and other "disqualified persons." Disqualified persons are generally those individuals who, any time in the last five years, were in a position to exercise substantial influence over the hospital, such as board members who have a right to vote, officers, certain high-admitting physicians, or other individuals who supervise the management, administration, operation, or finances of the hospital or one of its departments.[7] The Form 990 reporting obligations arise in several areas depending on both the relationship of the physician to the hospital and the type of benefit involved. The hospital may also need to report benefits provided to group practices (as opposed to individual physicians). If a benefit is provided as part of a group practice's professional service agreement with a hospital for example (such as parking provided to physicians who staff its radiology department pursuant to an exclusive contract), these benefits may more appropriately be considered as provided by the hospital to the group practice, as opposed to an individual physician in the group practice.

III. Recommendations for Developing and Implementing a Policy and Mechanism for Tracking Gifts and Incidental Benefits

A. Gather Facts

The first step in developing an effective policy for the provision of gifts, incidental benefits, and other business courtesies to medical staff physicians is to evaluate and assess what types of gifts and benefits are currently being offered, to whom, and under what circumstances. This net should be cast with the goal of uncovering all such items and benefits, including those that might be offered to a physician's immediate family members or office staff, and those that may be offered from different offices or "cost centers" within the hospital. Examples of what to track and make the subject of a centralized policy are: courtesy discounts; meals; donuts and bagels; concierge service; rounds of golf; tennis court fees; health club discount; sporting event tickets; concert tickets; art exhibit or lecture tickets; training and support services; lodging; cell phones, pagers; cocktail parties; movie and play tickets; holiday ham or turkey; flowers; logo gifts (e.g., clothing, pen, golf balls, duffel bag), CME courses; parking; commemorative plaque; retirement gift; office supplies and stationery; and any other items or services of value. Depending on what items are being provided, query whether they are being provided pursuant to a hospital or department-wide policy or on an ad-hoc basis. Also determine who the decision-maker is with respect to each of the items and what factors he/she might consider in determining what is provided to whom.

B. Conduct an Analysis Under Applicable Laws

Next, analyze the categories of gifts and benefits currently being provided (or that the hospital has determined it would like to provide) under the Stark Law, the Anti-Kickback Statute, and the Tax Requirements, along with any applicable state laws. Determine which practices the hospital is comfortable with and which it would like to offer only under certain circumstances or if certain internal approvals are in place, or that it would like to discontinue entirely. Deciding which course of action to follow for particular items and services is often a balancing act and a question of risk tolerance. For example, limiting these gifts to the strict parameters of the "non-monetary compensation up to $300" exception and the "medical staff incidental benefits" exception may provide the most certainty and lowest risk (if properly tracked), but a variety of other factors may allow for greater flexibility by relying on a host of other Stark Law exceptions (albeit with more intensive and costly monitoring and more in-depth involvement by legal and compliance staff to interpret the scope of the other exceptions).

C. Develop and Implement a Written Policy

In developing a written policy, consider including specific cate-

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gories of items or benefits that the hospital has clearly determined to prohibit, and an approval process for those that it may allow under certain circumstances. The policy should also identify the "responsible individual" within the legal or compliance department for addressing questions and facilitating approvals. The policy may also include checklists or a sample approval form to help streamline the approval process. The policy should be written in "layperson" terms, but could reference the specific laws that are driving the policy or could tie back to a summary of applicable laws developed by the hospital's legal department or compliance staff. The policy should be updated from time to time, but at least annually (e.g., to reflect new Stark Law dollar amount thresholds and changes in laws and regulations, and to incorporate changes in hospital practices). Hospital leaders and staff should have input into drafting the policy and be educated on and receive a copy of the policy when it is finally developed and implemented.

D. Develop and Implement a Tracking Mechanism

Mechanisms for tracking the provision of gifts, incidental benefits, and other business courtesies offered to medical staff physicians may be very sophisticated (e.g., individual physician key cards swiped each time a physician parks for free or enters the doctor's lounge for a free meal, etc.), while others may be more basic (e.g., spreadsheet with simple formulas included to automatically tally running totals as new benefit programs are logged). Ultimately, the mechanism selected will be driven by the extent and nature of gifts and benefits provided to physicians by the hospital. The critical point, however, is that the items and services be tracked so that Stark Law-driven thresholds (whether per gift or in the aggregate) will not be exceeded, the hospital can gauge its level of risk under the Anti-Kickback Statute, and tax restrictions and reporting obligations can be met.

* Asha B. Scielzo, Esq. is an Associate in the Washington, D.C. office of Jones Day. She may be reached at (202) 879-5449 or abscielzo@jonesday.com.

** Gerald M. Griffith is a Partner in the Chicago office of Jones Day. He may be reached at (312) 269-1507 or ggriffith@jonesday.com.

*** Travis F. Jackson is an Associate in the Columbus office of Jones Day. He may be reached at (614) 281-3833 or tfjackson@jonesday.com.

Endnotes

1 Although state laws are not discussed here, they must certainly be considered in developing a policy. Some state laws are potentially broader in scope than federal laws, and apply to both private and governmental payors.

2 The direct application of the Stark Law to Medicaid covered services is unclear. The Stark Law itself only prohibits referrals for designated health services where payment for such services may be made by Medicare. *See, e.g.*, 42 U.S.C. §1395nn(a)(1)(A) (stating certain referrals prohibited for which "payment may otherwise be made under this subchapter. . . ."). After the adoption of the Stark Law, Congress linked federal funding of state Medicaid programs, in part, to Stark Law compliance. Title XIX of the Social Security Act, which governs Medicaid, prohibits a state from using any federal funding to pay for designated health services provided pursuant to a referral that the Stark Law would prohibit. *See, e.g.*, 42 U.S.C. §1396b(s) (2006). CMS has yet to issue regulations indicating how it will apply the Stark Law to referrals of Medicaid services. For purposes of developing a policy for the provision of items and gifts to medical staff physicians, hospitals should assume application of the Stark Law to all physicians who refer patients to the hospitals, whether Medicare patients or others.

3 The "compliance training" exception only applies to training provided to physicians (or immediate family members or office staff) who practice in the hospital's local community or service area and only if the training is held within the local area. The training may cover the basic elements of establishing and operating a compliance program, specific federal/state healthcare program requirements (e.g., billing, coding, reasonable and necessary standard, documentation, unlawful referrals), and federal or state laws regarding provider conduct, but may not include continuing medical education.

4 *See generally United States v. LaHue*, 261 F.3d 993 (10th Cir. 2001), cert. denied, 122 S.Ct. 819 (2002); *United States v. McClatchey*, 217 F.3d 823 (10th Cir. 2000); *United States v. Davis*, 132 F.3d 1092 (5th Cir. 1998); *United States v. Kats*, 871 F.2d 105 (9th Cir. 1989); *United States v. Greber*, 760 F.2d 68 (3d Cir. 1985). *See e.g. United States v. Bay State Ambulance and Hosp. Rental Serv., Inc.*, 874 F.2d 20 (1st Cir. 1989).

5 Treas. Reg. section 1.6041-2 (Form W-2); Treas. Reg. section 1.6041-1 (Form 1099); IRS Instructions to Form 1099-MISC, at p.1.

6 This article assumes that the benefits provided to members of the hospital medical staff represent fair market value compensation for the services that these persons provide to the hospital, and does not discuss the application of Code § 4958, which imposes excise tax penalties on certain individuals in connection with the payment or receipt of compensation in excess of fair market value.

7 The determination of whether an individual physician is a "disqualified person" for purposes of Code § 4958 is a fact-intensive analysis. It is recommended that each hospital work to examine its medical staff for purposes of identifying physicians who may be "disqualified persons," as reporting obligations with respect to these individuals will likely increase in the near future with anticipated revisions to Form 990.