

HEALTH LAW FOCUS

*A Periodic Newsletter Published by The Health Care Department of
Honigman Miller Schwartz and Cohn LLP*

ENRON WARNING SIGNS FOR HEALTH CARE

By Gerald M. Griffith and Cynthia F. Reaves

Most business people and professionals today have heard quite a bit about Enron, WorldCom and other recent corporate scandals. As a result of Enron alone, a major U.S. company declared bankruptcy, thousands of workers lost their pensions, one of the largest auditing firms in the world lies in ruins, and many of the companies which performed services for, or were otherwise connected to Enron, will suffer significant financial loss. The civil suits and criminal investigations are likely to continue for years.

The problems that wracked Enron, however, are not unique to the energy industry. Many of the same issues of adequate financial disclosure, excessive compensation, internal investigations and conflicts of interest (of officers and professionals) are present in every industry. Health care is no exception. Already we have seen new legislation, such as the Sarbanes-Oxley Act, regulating disclosure obligations, financial statement preparation, rotating auditors, audit committee independence and functions, waiver of codes of ethics, loans to directors and officers, and a variety of conflicts of interest (including auditor independence). Although Sarbanes-Oxley focuses on public companies, many health care providers expect the same type of rules to be applied to nonprofits. In that regard, the IRS is working on guidance on conflict of interest disclosure and policies, independence of audit committees and expanded disclosure of financial relationships with insiders. Many industry insiders have begun referring to these problems and reforms, or symptoms and cures, as "Enron-itis."

We are also seeing signs of state attorneys general following similar standards. In the case of the Allina system in Minnesota for example, the attorney general investigated potential conflicts of interest and excessive compensation involving officers and consultants in the system, as well the adequacy of the consolidated financial statements. The attorney general even applied the SEC public company auditor independence rules by

analogy to nonprofits. In other states, the increased enforcement activity also has taken the form of challenges to various mergers, affiliations, conversions and sales of nonprofit health care organizations and their facilities, such as Banner Health System; questions of control over charitable assets of a hospital and hospital closures, such as in the Intracoastal case; and alleged misuse of charitable assets, as in the AHERF and Hershey Trust cases. Although the players may differ from state-to-state, the trend is both clear and alarming for nonprofit health care organizations.

How can you tell if your organization is at risk for Enron-itis? Here are ten warning signs that may hint at trouble:

Large number of interested directors generally. Nothing draws the attention of regulators like a good conflict. It holds their interest like a good book. If the board is filled with interested directors, the regulators will have many "chapters" (such as corporate minute books, contracts and other records) to read, and read them they will with their feet on your corporate coffee table. Conflicts can exacerbate other problems, particularly if there are not adequate safeguards in place to assure that the organization is not being taken advantage of by interested directors. Similar considerations apply to conflicts of officers, auditors (e.g., with consulting work) and other professional advisors.

Missing or incomplete conflict disclosures. Some conflicts are often inevitable on boards today. Failure to disclose and address them on a timely basis (including contemporaneous documentation of resolved conflicts) can cast the organization in a suspicious light.

HMSC HEALTH CARE ATTORNEYS IN THE NEWS

Cynthia F. Reaves was appointed Chair of the HMOs and Health Plans Practice Group of the American Health Lawyers Association in Washington, D.C. AHLA is a national trade association comprised of over 10,000 professionals who provide advice and counsel to health care industry companies. Ms. Reaves was also appointed to the Nominating Committee of the Board of Directors of AHLA.

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Gerald M. Griffith was elected Chairperson of the Health Care Law Section of the State Bar of Michigan.

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No consideration of non-conflict alternatives. Conflict transactions are generally not prohibited. Failure to examine alternatives, however, leaves directors open to charges of breach of fiduciary duty and perhaps personal liability. Conflicts with professional advisors (e.g., auditor acting as consultant) may call into question the accuracy of the audit as well as the reliability of the consulting work regardless of the firm's qualifications.

Excessive return on investment for partners. Health care organizations are generally familiar with the fair market value restrictions on their operations. Those same considerations apply to partnerships and "co-investments," particularly those involving physicians. If your partner is reaping substantial profits on the investment, regulators are likely to assume it is for some nefarious purpose. Without proper documentation of fair market value and proper purposes, that is a difficult assumption to overcome.

"Reviewers" structured the deal; reviewers replaced. At times, professionals and clients do not always mesh for a variety of reasons. If that reason is a difference of opinion on compliance matters or because the reviewer comes across as too inflexible or obstructionist, replacing the professional with someone more "flexible" may be a focal point for strident government investigators. In Enron this complaint was aimed at the auditors, but it could be consultants or lawyers too. At a minimum, you should consult your compliance officer and in-house counsel before seeking to remove a professional and document the basis for the removal.

Incomplete documentation. Policies are good, and good policies are great. Failure to follow them, however, spells d-i-s-a-s-t-e-r. It is essential to have the right rules to live by to document the basics of transactions, including governance approvals and fair market value, community benefit, etc. It is even more important to carry out those policies. Failure to adhere to established documentation protocols could infer a desire to hide illegal or nefarious activity.

Reluctance to review matter with the board. This is akin to being afraid to talk to your parents. If you do not want to take a matter to the board or an appropriate board committee and choose instead to proceed without board approval then you could be asking for trouble. Regulators will want to know what information was provided to the board. Further, if board members fail to implement procedures to guard against renegade executives, they may be liable for breaching their fiduciary duty to the corporation.

Brief, infrequent or interrupted compliance agendas. Compliance is an important task. It also can be a time-consuming one. Failure to allow adequate time for full, uninterrupted discussion of compliance matters is one key symptom of Enron-itis. Compliance actions should be reflected in compliance committee meeting minutes.

Negative buzz words: push limits; high risk profile. Andersen documents indicate that the auditors told the audit committee that many of the transactions and accounting practices "push the limits"; or ones where "others could have a different view"; or were "at the edge"; or pose "a 'very significant' risk of 'form over substance transactions.'" Enron directors on the audit committee testifying before Congress did not recall the engagement partner using the phrase "push limits," or providing copies of his talking points but did acknowledge being aware that Enron was engaged in high-risk, innovative transactions.

Front page news test. The last symptom is perhaps the simplest to diagnose and the most often ignored, perhaps out of an expectation of

confidentiality. That expectation did not hold for many people in the Enron matter. So if you do nothing else, ask yourself one question: How would this transaction or arrangement look on the front page of the local newspaper? The answer may encourage you to ask a lot more questions.

If you would like a presentation on Enron-itis for your organization or board, please contact either of the authors. We make presentations of varying lengths for a fixed fee plus expenses. We also have available for purchase copies of a more detailed analysis of how Enron applies to the health care industry - Lessons for Healthcare from Enron: A Best Practices Handbook (American Health Lawyers Association 2002), edited by Mr. Griffith with chapters written by Mr. Griffith and Ms. Reaves among others.

CHANGES TO THE PROVIDER-BASED REGULATIONS

By Patrick G. LePine

On August 1, 2002, the Centers for Medicare and Medicaid Services ("CMS") published final regulations which substantively change the provider-based regulations and requirements for qualifying for provider-based status (the "Final Rule"). The Final Rule includes significant changes to the original provider-based regulations which were published on April 7, 2000.

The Final Rule was published in the Federal Register as part of the fiscal year 2003 changes to the hospital inpatient prospective payment system (at 67 Fed. Reg. 49982). The Final Rule (i) extends the application deadline for "grandfathered" facilities to the provider's first cost reporting period that begins after July 1, 2003; (ii) expands the list of facilities not subject to the provider-based requirements; (iii) simplifies the provider-based application process and removes the advance approval requirement; (iv) simplifies the requirements for on-campus facilities; (v) eliminates the prohibitions on joint ventures and the limitations imposed by management agreements for on-campus facilities; and (vi) includes new rules for the recoupment of payments made to a facility that does not meet the provider-based requirements. *(Please note that certain revisions to the EMTALA requirements for provider-based facilities, as proposed in the Federal Register on May 9, 2002 (67 Fed. Reg. 31404), are still in proposed form and are expected to be published as a final rule at a later date. The proposed revisions would eliminate the requirement that off-campus provider-based departments comply with EMTALA unless the off-campus department is a dedicated emergency room.)*

Extension of Grandfathering Period

Although the original provider-based regulations took effect for cost reporting periods beginning on or after January 10, 2001, Section 404 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (hereinafter "BIPA") included a "grandfathering" provision applicable to certain facilities "treated" as provider-based as of October 1, 2000. CMS has stated that facilities deemed to be treated as provider-based include those facilities with formal written determinations from CMS as to provider-based status as well as those facilities which do not have a written determination but were being reimbursed as provider-based as of October 1, 2000. Pursuant to Section 404(a) of BIPA, any facility "treated as provider-based in relation to a hospital or critical access hospital" as of October 1, 2000 shall "continue to be treated as provider-based" until October 1, 2002. Under the Final Rule, 42 CFR § 413.65(b)(2) has been revised to provide that the "grandfathering"

provision is extended until the start of the provider's first cost reporting period beginning on and after July 1, 2003 (*i.e.*, extend the application deadline for "grandfathered" facilities to the provider's first cost reporting period that begins after July 1, 2003.)

Exempted Facilities

The Final Rule expands the list of those facilities not subject to the provider-based requirements, including independent diagnostic testing facilities that furnish only services paid under a fee schedule, such as facilities that furnish only screening mammography services; departments of providers that do not furnish types of health care services for which separate payment could be claimed under Medicare or Medicaid (for instance, laundry or medical records departments); and ambulance services.

Revision of Application Requirement

The original provider-based regulations (at 42 CFR § 413.65(b)(2)) established an explicit application requirement for all facilities seeking provider-based status (except for grandfathered facilities). In response to concerns that the application requirements create an unnecessary paperwork burden for hospitals, the Final Rule simplifies the application process and establishes different application requirements for on-campus and off-campus facilities.

In lieu of submitting an application, an on-campus facility (*i.e.*, located on a hospital's main campus) is now required to submit an attestation stating that the facility meets the applicable provider-based criteria (as set forth in 42 CFR § 413.65 (d)), and, if it is a hospital, to provide an attestation that the facility will fulfill the obligations of hospital outpatient departments and hospital based entities (as described in 42 CFR § 413.65 (g)). The provider is also required to maintain documentation of the basis for its attestations and to make such documentation available to CMS upon request. Likewise, in lieu of submitting an application, an off-campus facility is now required to submit an attestation stating that the facility meets the applicable provider-based criteria (as set forth in 42 CFR § 413.65 (d) and (e)), and, if the facility is operated as a joint venture or under a management contract, the requirements in 42 CFR § 413.65 (f) or (h), as applicable. If the main provider is a hospital, the hospital is also required to provide an attestation that the facility will fulfill the obligations of hospital outpatient departments and hospital based entities (as described in 42 CFR § 413.65 (g)). The provider is also required to supply documentation of the basis for its attestations to CMS at the time it submits its attestations.

Additionally, there is no longer an explicit requirement that a provider obtain provider-based approval before a facility is treated as provider-based for billing or cost reporting purposes. Moreover, if a provider submits a complete attestation of compliance with the provider-based requirements, the provider may bill and be paid for services as provider-based until the time that CMS determines that the facility does not meet the provider-based requirement.

Simplification of Requirements for On-Campus Facilities

Under the original provider-based regulations, all facilities seeking provider-based status were required to meet a common set of requirements relating to common licensure, operation under the ownership and control of the main provider, administration and supervision, integration of clinical services, financial integration, public awareness and location. In

recognition that the current regulations may restrict legitimate business arrangements that do not lead to abusive practices or disadvantage Medicare beneficiaries, the Final Rule simplifies the requirements applicable to facilities located on the main campus of the provider. All facilities seeking provider-based status are now required to comply with the existing requirements relating to common licensure, integration of clinical services, financial integration and public awareness, and the obligations of hospital outpatient departments and hospital-based entities; however, the requirements relating to operation under the ownership and control of the main provider, administration and supervision, integration and location are now applicable only to off-campus facilities.

Joint Ventures and Management Agreements Acceptable for On-Campus Facilities

The original provider-based regulations prohibited provider-based status for any facility or organization owned by a joint venture and imposed strict requirements on entities operated under management agreements. The Final Rule eliminates these prohibitions entirely for all on-campus facilities; however, off-campus facilities remain subject to the prohibition of joint ventures and to the limitations imposed on management agreements.

Joint Ventures

The original provider-based regulations provided that "a facility or organization cannot be considered provider-based if the entity is owned by two or more providers engaged in a joint venture." Consistent with CMS's view that a higher degree of integration can be presumed for on-campus facilities and in recognition of the need to promote reasonable cooperation among providers and avoid costly duplication of specialty services, the Final Rule limits the scope of the prohibition on provider-based status for joint ventures to facilities not located on the campus of any potential main provider, thus allowing provider-based status for joint venture facilities located on the campus of a main provider so long as all other requirements for provider-based status are met.

Management Agreements

Under the original provider-based regulations, facilities operated under management agreements were considered provider-based only if they meet all of the following criteria:

- (i) The staff of the facility, other than management staff, are employed by the provider or by another organization, other than the management company, which also employs the staff of the main provider;
- (ii) The administrative functions of the facility are integrated with those of the main provider;
- (iii) The main provider has significant control over the operations of the facility; and
- (iv) The management contract is held by the main provider itself, not by a parent organization that has control over both the main provider and the facility.

Under the original provider-based regulations, the above requirements applied equally to on-campus and off-campus facilities. Consistent with CMS's intent to simplify provider-based requirements for on-campus facilities, the Final Rule restricts the applicability of the

above-described requirements to off-campus facilities. Further, the Final Rule: (i) specifies that a facility operated under a management contract may be considered provider-based only if the main provider (or an organization that also employs the staff of the main provider and that is not the management company) employs the staff of the facility who are directly involved in the delivery of patient care, except for management staff and staff who furnish patient care services of a type that would be paid for by Medicare under a fee schedule; and (ii) clarifies that so-called "leased" employees (that is, personnel who are actually employed by the management company but provide services for the provider under a staff leasing arrangement) are not considered to be employees of the provider for purposes of the requirements relating to facilities operated under management contracts.

Recoupment and Continuation of Payment

Under the Final Rule, if CMS learns that a provider has treated a facility or organization as provider-based and the provider did not request a determination of provider-based status from CMS, and CMS determines that the facility or organization did not meet the requirements for provider-based status, as applicable, CMS will take the following steps and provide notice to the provider accordingly:

1. Payments for past cost reporting periods may be reviewed and recovered. CMS will recover the difference between the amount of payments that actually was made to that provider for services at the facility or organization and an estimate of the payments that CMS would have made to that provider for services at the facility or organization in the absence of compliance with the requirements for provider-based status. Recovery would be for all cost reporting periods subject to reopening.
2. Future payments for services in or at the facility or organization will be adjusted to approximate the amounts that would be paid for the same services furnished by a freestanding facility.
3. Continued payments to the provider for services of the facility or organization will be made only in accordance with 42 CFR § 413.65(j)(5).

Note that unlike the original provider-based regulations, no adjustment in payment will be made until after CMS determines that the facility or organization does not meet the provider-based requirements. Moreover, recovery of past payments will be limited in certain circumstances. If a provider did not request a provider-based determination for a facility by October 1, 2002, but is included in the grandfathering period through July 2003, CMS will not recoup payments for any period before the provider's cost reporting period beginning on or after July 1, 2003. In addition, CMS will not recover any payments for any period before the beginning of the hospital's cost reporting period beginning on or after January 10, 2001, if during all of that period the criteria for the "good faith" exception are met as follows: (i) the requirements for licensure and public awareness; (ii) all facility services were billed as if they were furnished by a department of a provider, a remote location, or satellite, as applicable; and (iii) all professional services were billed with the correct site of service indicator.

MICHIGAN PROMPT PAY LAW TAKES EFFECT

By Cynthia F. Reeves

Effective October 1, 2002, the Michigan Insurance Code and the Blue Cross/Blue Shield of Michigan ("BCBS") statutes will be amended to implement the Michigan Prompt Pay Law (the "Law" or the "Prompt Pay Law"). The Prompt Pay Law amends MCL 500.2006 (MCL 550.1403 for BCBS) to require the establishment of timely claims processing and payment procedures to be used by health professionals, health facilities, health insurers, health maintenance organizations ("HMOs") and BCBS. The Prompt Pay Law applies to all health care claims with dates of service on or after the effective date and creates a right to interest payments for health care providers for late paid claims. The Prompt Pay Law does not apply to the processing and payment of Medicaid claims.

1. **Prompt Claims Payment:** Under the Law, clean claims must be paid within 45 days after receipt by a health plan (defined to include insurers, MEWAs, HMOs and BCBS). The Law applies to health plans when paying claims to health professionals and facilities (that are not pharmacies) that do not involve claims under the motor vehicle protection or the Worker's Disability Compensation Act. Under the Law, a clean claim that is not paid within 45 days will bear simple interest at a rate of 12% per annum.
2. **Notice of Deficiency:** A health plan must notify the health provider (*i.e.*, the health professional or health facility) within 30 days after receipt of a claim by the health plan of all known reasons that prevent the claim from being a clean claim. The notice will serve to toll the 45-day payment requirement until the date on which the provider submits a response. The health provider then has 45 days within which to submit a response to correct all defects. Once the response is submitted, the original 45-day time period repayment obligation recommences and, assuming that the provider's response makes the claim a clean claim, the health plan is required to make payment within this original 45-day claim period, excluding the time period which had been tolled for provider response. Note that a health provider may not resubmit a claim for the same service during the 45 days following the original submission (except in order to respond to defects identified by the health plan).
3. **Continued Deficiency:** If a health provider's response does not result in a clean claim, the health plan must notify the provider of the claim denial and the reasons for the denial within the original 45-day claim period time frame.
4. **Partial Determination:** If a health plan determines that one or more services on a claim are payable, it must pay for those services and may not deny the entire claim because one or more services listed are defective. However, this requirement may be avoided if the health plan and provider have an overriding contractual reimbursement arrangement.
5. **Application to ASO Services:** The Law does not apply to insurers or BCBS with respect to payments made to such entities pursuant to an administrative services only or cost-plus arrangement.
6. **Court Action/Administrative Procedures:** A provider which alleges violation of the Law may institute court action in addition to seeking relief under administrative rules administered by the Commissioner of Insurance (the "Commissioner"). The Office of

Financial and Insurance Services may impose civil fines for patterns of violation of these requirements. However, a BCBS health plan would be subject only to the procedures and penalties provided under section 402 of the Nonprofit Health Care Corporation Reform Act and to the imposition of a civil fine by the Commissioner. A health plan may not terminate or otherwise discriminate against a health provider which files a claim for violation of the Prompt Pay Law.

7. **Precedential Authority:** The amendments supersede the existing provisions of the Insurance Code and BCBS statute regarding prompt processing of claims.
8. **Statutory Definition of Clean Claim:** The Law sets forth the definition of what constitutes a clean claim. A "clean claim" means a claim that does all of the following:
 - (i) Identifies the health professional or health facility that provided service sufficiently to verify, if necessary, affiliation status and includes any identifying numbers.
 - (ii) Sufficiently identifies the patient and health plan subscriber.
 - (iii) Lists the date and place of service.
 - (iv) Is a claim for covered services for an eligible individual.
 - (v) If necessary, substantiates the medical necessity and appropriateness of the service provided.
 - (vi) If prior authorization is required for certain patient services, contains information sufficient to establish that prior authorization was obtained.
 - (vii) Identifies the service rendered using a generally accepted system of procedure or service coding.
 - (viii) Includes additional documentation based upon services rendered as reasonably required by the health plan.
9. **Bill Submission:** A provider has one year from the date of service or date of discharge to bill a health plan in order for a claim to be a clean claim.

FEDERAL DISTRICT COURT CONCLUDES LITHOTRIPSY NOT A DESIGNATED HEALTH SERVICE UNDER STARK LAW

By: Michael J. Philbrick

In a recent federal court ruling issued July 12, 2002, the District Court for the District of Columbia (*American Lithotripsy Society and Urology Society of America v. Thompson*, Civil Action 01-01812) held that lithotripsy is not a "designated health service" ("DHS") for purposes of the Stark Law, and that the Centers for Medicare and Medicaid Services ("CMS") exceeded its statutory authority under the Administration Procedures Act ("APA") in promulgating regulations to that effect. CMS regulations classified lithotripsy as an inpatient or outpatient hospital service, one of the categories of DHS under the Stark Law. Accordingly, referrals by urologists for lithotripsy to entities with which these physicians have a financial relationship were statutorily prohibited, unless the arrangement fit within an exception to the Stark Law.

Lithotripsy is a medical procedure performed by urologists that removes kidney stones through the use of a lithotripter, a machine that generates shock waves that break the urinary tract stones into small pieces that can be passed through the urinary tract and expelled out of the body. Nearly half of the lithotriptors in the U.S. are currently owned by urologists.

In 1989, Congress enacted legislation ("Stark I") to address over-utilization of certain medical services by physicians whose referrals potentially were driven by financial gain rather than medical necessity. As the Court noted, Stark I was modeled upon a Florida statute that prohibited all physician self-referrals, but made an express exception for lithotripsy. This exception recognized that physician ownership of lithotripsy centers did not pose a risk of over-utilization. Stark I, in final form, was narrowed and prohibited physician self-referrals solely with respect to clinical laboratory services.

In 1993, Congress enacted further self-referral legislation ("Stark II"), which expanded the original prohibitions to include a class of "designated health services" in addition to clinical laboratory services. These DHS included "inpatient and outpatient hospital services." Lithotripsy was not explicitly included among the designated health services, nor were any of the enumerated designated health services further defined in the statute.

CMS issued final regulations implementing Stark II in January 2001. Such regulations expressly included lithotripsy as an inpatient or outpatient hospital service, and thus physicians were prohibited from referring patients for lithotripsy services to entities in which they have a financial arrangement unless a particular exception was satisfied.

In the instant case, the plaintiffs, American Lithotripsy Society and Urology Society of America, brought the action alleging a violation of the APA. In an APA action, the Court must determine whether Congress has directly spoken to the precise question at issue. If Congress' intent is clear, this expression of intent is determinative on the issue. Any regulation that is contrary to clear congressional intent must be set aside. Thus, the Court undertook a detailed examination of the evidence to determine whether Congress had directly spoken to the issue of including lithotripsy as a designated health service under Stark II.

The Court examined the statute in detail to determine if the term "inpatient and outpatient hospital services" was plainly and unambiguously defined. The Court also examined the statutory purpose and legislative history of the Stark Law. The Court noted that Stark I, when initially crafted as a blanket prohibition, specifically excluded lithotripsy from the medical services prone to over-utilization. Stark I was eventually enacted in a less comprehensive form which only prohibited clinical laboratory services, and thus the exception for lithotripsy was no longer necessary. Likewise, Stark II was not enacted as a blanket prohibition but only with regard to specific DHS. During the legislative debate and sessions involving Stark II, Congressman Stark, the bill's sponsor, affirmed the understanding that the provision banning inpatient and outpatient hospital services was not intended to apply to physician-owned lithotripsy facilities that furnish services under arrangement with a hospital.

The Court found that the lack of any mention of lithotripsy in the Stark II statute itself, the legislative history of both Stark I and Stark II, and the statute's purpose demonstrated a clear intent on the part of Congress not to subject lithotripsy to the ban on self-referrals by including it in "inpatient and outpatient hospital services." Thus, the Court held that CMS' regulations classifying lithotripsy as an inpatient or outpatient hospital service under Stark II violated the APA and must be set aside.

CMS filed an appeal on September 6, 2002 challenging the District Court's ruling. If CMS remains unsuccessful on appeal, lithotripsy would be effectively excluded from the definitions of inpatient or outpatient

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hospital services and designated health services under the Stark Law. Referrals for such services thus would not be subject to the prohibition against self-referrals. This case illustrates that on occasion it may be fruitful to challenge regulatory actions directly.

MICHIGAN COURT OF APPEALS HOLDS THAT SUCCESSOR LIABILITY ATTACHES TO HOSPITAL THAT PURCHASED PHYSICIAN PRACTICE

By: Zachary A. Fryer

In *Craig v. Oakwood*, the Michigan Court of Appeals held that Henry Ford Hospital could be liable as a corporate successor to the professional corporation of a physician practice it had purchased, even though the physicians in that practice had formed a new professional corporation (P.C.) that contracted with the corporation purchased by the hospital, and the corporation owned by the hospital had been converted to a business corporation and no longer provided physician services through its employees.

The case arose from injuries suffered by a newborn, which caused him to suffer cerebral palsy and mental retardation. The injured minor sued the two physicians involved in his delivery, the professional corporation that employed them and Oakwood Hospital for malpractice. Henry Ford Hospital was sued as a successor to the professional corporation that the physicians had been employed by at the time of the injury.

Henry Ford Hospital had acquired the physician practice by purchasing all of the stock of the existing corporation, which was converted from a professional corporation to a business corporation immediately before the transfer (a professional corporation may practice medicine if all of its shareholders are physicians, but cannot be owned by another corporation; a business corporation can be owned by another corporation but cannot practice medicine). The business corporation had the same corporate identification number as the P.C. from which it had been converted, and the court noted that its articles of incorporation were amended and restated rather than all new.

Most of the physicians who had practiced with the old P.C. formed a new P.C., along with several other physicians who had not been part of the old P.C. The original corporation that was purchased by Henry Ford Hospital owned and operated the clinic in the same location as before, contracting with the new P.C. for physician services. The business corporation owning the clinic was subsequently dissolved, so that Henry Ford Hospital owned the clinic directly.

Under Michigan law, when two corporations merge, the resulting corporation has the same obligations as the previous corporations. Successor liability can exist whether there is an express legal merger or a de facto merger. The Michigan Supreme Court has looked at four factors to find successor liability in a de facto merger: continuation of the enterprise of the seller corporation, particularly as shown by retention of key personnel, assets, business operations, and the corporate name; the seller corporation ceasing operations and dissolving soon after the transaction; assumption by the purchasing corporation of liabilities and obligations necessary for the continuation of the normal business operations of the seller; and the purchasing corporation holding itself out as the effective continuation of the seller.

The court of appeals looked at the facts of the transaction in which

Henry Ford Hospital acquired the P.C. in light of these factors and found that all the requirements for imposing successor liability were present. The court stated that the new P.C. was not a successor to the old P.C. because it had taken on new physicians and no longer owned the realty it used nor managed the clinic. Instead, the business corporation owned by the hospital was the successor, because it was legally a continuation of the old P.C. and had continued the business operations of the old P.C. at the same location as before. When the business corporation was dissolved into the hospital, it was appropriate that the hospital succeed to its liabilities. And while Michigan courts had not previously addressed successor liability for personal professional services, the court found no reason not to impose it.

Craig v. Oakwood is a cautionary note to potential purchasers of professional practices. Even though a corporation has converted its legal status from a professional corporation to a business corporation and ceased providing professional services, it may still be held liable for professional malpractice resulting from acts of its professional employees when it was a P.C. Prospective purchasers of physician or other professional practices should carefully review the known liabilities and likelihood of unknown liabilities of the practice to be acquired, and carefully structure the transaction to account for and minimize the likelihood of successor liability for professional malpractice.

SENATE BILL 517 ENACTED

By: Michael J. Philbrick

Under the Michigan Public Health Code, the Department of Consumer and Industry Services (the "Department") may investigate activities related to the practice of licensed health professionals and must report its findings to the appropriate disciplinary subcommittee. The disciplinary subcommittee may then take disciplinary action if certain grounds for action are found. Available disciplinary action includes probation, denial of license, revocation of license, community service, and fines. Actionable grounds for such disciplinary action include unprofessional conduct by a licensed health professional. Under the prior law, unprofessional conduct included "directing or requiring an individual to purchase, or secure a drug, device, treatment, procedure or service from another person, place, facility, or business in which the licensee has a financial interest." MCL 333.16221. In the well-known "*Indenbaum*" case, the court found that a referral by a physician to an entity partially owned by the physician constituted a violation of the statute, even though the referring physician, via a posted notice in the office, disclosed his ownership interest to the patient and gave the patient the option of being referred to another facility for the necessary services. (*Indenbaum v. Michigan Bd. of Medicine*, 213 Mich. App. 263, 274, 539 N.W.2d 574 (1995)).

Senate Bill 517, introduced on May 30, 2001 and amended by the House, was approved by the Governor and filed with the Secretary of State on June 3, 2002 as Act No. 402 of the Public Acts of 2002 ("the Amendment"). The Amendment, which was effective as of June 3, 2002, modifies the definition of what actions will constitute unprofessional conduct for licensed health professionals.

The Amendment

The Amendment provides that it is unprofessional conduct for any non-physician licensee to require that an individual purchase or secure a device, drug, treatment, procedure or service from another person, place, facility or business in which the non-physician licensee has a financial

interest. Under the Amendment, it shall constitute unprofessional conduct for a physician licensee to make a referral for a designated health service which would violate Section 1877 of Part D of Title XVIII of the Social Security Act (the "Stark Law"). In its determination, the disciplinary subcommittee shall apply the Stark Law and the regulations thereunder without regard as to the source of payment for the designated health service. Additionally, physicians who make referrals under the Stark Law must accept a proportionate share of patients eligible for Medicaid, as well as accepting Medicare or Medicaid payment as payment in full for a service, treatment or procedure for which the physician licensee refers an individual and in which he or she has a financial interest, unless the physician owns all or part of the facility where the referred procedure is performed and reimbursement is not at a minimum of the appropriate Medicaid or Medicare outpatient fee schedule. The Department shall take notice of any federal revisions of the Stark Law or the regulations thereunder, and may incorporate such changes into the Michigan statute by reference if such changes pertain to referrals by physicians and protect the public. The Department shall also prepare annual reports to determine the impact of the amendment on the access to medical care for the uninsured and Medicaid patients.

Reference to Federal Law

The Amendment incorporates the federal regulations into state statute by making a referral by a physician of a designated health service that violates the Stark Law and its regulations unprofessional conduct in Michigan. The Stark Law generally prohibits a physician from referring a patient to an entity for health services if there is a financial relationship between the referring physician, or his or her immediate family, and the entity, and if there is reimbursement at least in part from a federal health program, unless a specific exception is met. Affected financial relationships include both ownership and compensation arrangements. The federal prohibition only applies if the particular medical service being referred is on the specific list of "designated health services" — those medical services that the federal government has determined may be subject to over-utilization. In addition, the reimbursement for the designated health service must be made in part or in whole by a federal program such as Medicare or Medicaid. Finally, there are numerous exceptions to the prohibition of referrals such as where the referral is made to a physician in the same group practice, in-office ancillary services, or where the same physician provides the additional medical service.

Although attempting to incorporate the Stark Law into Michigan law, the Amendment eliminates the federal requirement that the designated health service must be reimbursed in whole or in part by a federal health program. It provides that the disciplinary subcommittee shall apply the Stark Law and the regulations without regard as to the source of payment for the designated health service. Thus, not only are Medicare and Medicaid services affected by the Amendment, so too are non-federal health programs and private health insurance programs.

Implications

Proponents of the Amendment described it as a codification of the federal regulations, but by revising existing state law and replacing portions of existing state law with federal law, state law is dramatically changed.

Non-Physician Licensee: The Amendment includes in its definition of unprofessional conduct, a licensed professional, other than physicians, requiring that an individual purchase or secure a drug, device, treatment, procedure or service from another person, place or facility or business in which the licensee has a financial interest. This language, though similar to the previous statutory language, is however, less restrictive because

unprofessional conduct only includes a non-physician licensee requiring an individual to purchase or secure a drug, device, treatment, procedure or service. The previous statutory definition of unprofessional conduct included a non-physician licensee requiring or directing that an individual purchase or secure a drug, device, treatment, procedure or service. The Amendment will not prohibit a non-physician licensee from directing, suggesting or otherwise influencing a person to purchase or secure a drug or device or medical service from a person or facility in which the non-physician licensee has financial interest. Presumably, anything less than a specific requirement will not constitute unprofessional conduct for a non-physician licensee.

Physicians: Prior Michigan law effectively prohibited a physician licensee from referring or directing a patient for any medical service in which that physician licensee had a financial interest. The Amendment provides that only those referrals by a physician which would violate the Stark Law will constitute unprofessional conduct. Prior Michigan law applied to all health services, drugs, devices, and procedures, not merely to a list of services which the federal government has determined are subject to over-utilization. The Amendment will not prohibit the referrals of medical services that are not on the federal list of designated health services, nor will the Amendment prohibit the referral of designated health services where the referral fits into one of the numerous exceptions. The use of the Stark Law standards also means that compensation arrangements between physicians and any facility are subject to the Michigan self-referral laws.

Under the Amendment, it will constitute unprofessional conduct for a physician who makes referrals (as defined under the Stark Law) to not accept a reasonable proportion of patients eligible for Medicaid, and to refuse to accept payment from Medicare or Medicaid as payment in full for a treatment, procedure, or service for which the physician refers the individual and in which the physician has a financial interest. Thus, if the referring physician makes a referral to an entity in which he or she has a financial interest, whether ownership, investment or compensatory, the referring physician must accept a reasonable proportion of Medicaid patients, and the entity or person to which the patient has been referred must accept the Medicaid or Medicare payment in full. Such a requirement does not apply, however, to a physician who owns all or part of the facility in which he or she provides surgical services if a referred surgical procedure he or she performs in the facility is not reimbursed at a minimum of the appropriate Medicaid or Medicare outpatient fee schedule. The Amendment does not define "reasonable proportion" and thus it may be subject to interpretation by the Department. This provision was designed to address concerns that physicians referring individuals to facilities in which they have a financial interest would stop accepting Medicaid or Medicare patients and would refuse to accept Medicaid and Medicare payments as payment in full for their services.

Hospitals: The federal regulations, as implemented into state law, allow for several exceptions including group practices, in-office ancillary services, and services that the physician provides him or herself. Additionally, the federal regulations only apply to designated health services, some of which are profitable and some of which are not. This Amendment will allow physicians to refer patients for services that are not included in the list of designated health services to entities in which they have a financial interest, as well as refer patients for services to entities in which they have a financial interest under a particular exception. Hospitals might begin to see a greater concentration of patients requiring designated health services or services not generally provided for at for-profit medical facilities in which physicians have a financial interest.

Department Functions: The Amendment provides that the Department is required to review all future revisions of the Stark Law

and regulations. If the Department determines that the revisions pertain to referrals by physicians and protects the public, the Department may incorporate the revisions into the Michigan statute by reference. If the revisions are incorporated into the statute, no changes can be made to the revision as enacted federally. Additionally, the Department must prepare an annual report, beginning one year from the effective date of the Amendment, addressing any impact on access to care for the uninsured and Medicaid patients. The Department must report the number of referrals of uninsured and Medicaid patients to purchase or secure a drug, device, treatment, procedure or service from another person, place, facility, or business in which the licensee has a financial interest. The Department must prepare the annual report for three years. This report will highlight if licensees are referring non-profitable services, uninsured individuals, and Medicaid patients disproportionately to non-profit hospitals instead of equally to facilities, persons, or business in which they have a financial interest. The Amendment does not specify the reporting requirements of licensees, nor the method of tracking such information by licensees or collecting of such information by the Department.

The full impact of the Amendment will be highlighted not only in the Department's report, but will also be demonstrated in the any increase in the number and types of referrals made by non-physician licensees and physicians to entities in which they have a financial interest. A direct consequence will, however, be an increase in competition between hospitals and physicians for providing medical services and treatments.

PHYSICIAN RECRUITING: ANTIKICKBACK STATUTE COMPLIANCE

By: Ann T. Hollenbeck

Recruiting incentives paid to physicians by hospitals and physician groups have traditionally been scrutinized by the Office of Inspector General ("OIG") of the Department of Health and Human Services ("DHHS") as possible disguised payments in exchange for referrals that potentially violate the federal Antikickback Statute. The Antikickback Statute provides criminal penalties for individuals and entities that knowingly and willfully offer, pay, solicit or receive remuneration intended to induce the referral, purchasing, leasing, ordering or arranging for any good, facility, service or item reimbursed by the Medicare program or other state health care programs, such as Medicaid. The types of remuneration covered include kickbacks, bribes and relates, whether made directly or indirectly, overtly or covertly, or in cash or in kind. Violations of the Antikickback Statute are classified as felonies, with each violation punishable by a fine of up to \$25,000 and/or imprisonment up to 5 years.

In 1991, the OIG published, in final form, the practitioner recruitment safe harbor ("Safe Harbor") with the intention of promoting beneficiary access to quality health care by permitting communities that have difficulty attracting necessary professionals to offer inducements to such professionals without running afoul the Antikickback Statute. Physician recruiting arrangements that comply with the Safe Harbor will not be challenged by the OIG; however, the Safe Harbor only applies to physician recruiting activities where the recruited practitioner's primary place of practice will be located in a health professional shortage area as defined in DHHS regulations (a "HPSA") for the practitioner's specialty area, and requires compliance with all of the following 9 standards:

1. The arrangement is set forth in a written agreement signed by the parties that specifies the benefits provided by the entity, the terms under which the benefits are to be provided, and the obligations of each party;

2. If a practitioner is leaving an established practice, at least 75% of the revenues of the new practice must be generated from new patients not previously seen by the practitioner at his or her former practice;
3. The benefits are provided by the entity for a period not in excess of 3 years, and the terms of the agreement are not renegotiated during this 3-year period in any substantial aspect; provided, however, that if the HPSA to which the practitioner was recruited ceases to be a HPSA during the term of the written agreement, the payments made under the written agreement will continue to satisfy this paragraph for the duration of the written agreement (not to exceed 3 years);
4. There is no requirement that the practitioner make referrals to, be in a position to make or influence referrals to, or otherwise generate business for the entity as a condition for receiving the benefits; provided, however, that for purposes of this paragraph, the entity may require as a condition for receiving benefits that the practitioner maintain staff privileges at the entity;
5. The practitioner is not restricted from establishing staff privileges at, referring any service to, or otherwise generating any business for any other entity of his or her choosing;
6. The amount or value of the benefits provided by the entity may not vary (or be adjusted or renegotiated) in any manner based on the volume or value of any expected referrals to or business otherwise generated for the entity by the practitioner for which payment may be made in whole or in part under Medicare or a state health care program;
7. The practitioner agrees to treat patients receiving medical benefits or assistance under any federal health care program in a nondiscriminatory manner;
8. At least 75% of the revenues of the new practice must be generated from new patients residing in a HPSA or a Medically Underserved Area ("MUA") or who are part of a Medically Underserved Population ("MUP"); and
9. The payment or exchange of anything of value may not directly or indirectly benefit any person (other than the practitioner being recruited) or entity in a position to make or influence referrals to the entity providing the recruitment payments or benefits of items or services payable by a federal health care program.

Because compliance with all 9 standards of the Safe Harbor may prove difficult for many recruiting arrangements, the publication of Advisory Opinion 01-04 last year (the "Opinion") was significant. In the only advisory opinion released to date by the OIG on the subject of physician recruiting, the OIG concluded that sanctions under the Antikickback Statute should not be imposed in connection with a hospital's recruitment of a physician to provide services in the hospital's service area. The Opinion is noteworthy because it signifies the OIG's recognition that the failure of a recruiting package to satisfy the Safe Harbor will not necessarily be deemed to result in a violation of the Antikickback Statute. Further, the Opinion provides valuable guidance as to the factors that will be considered by the OIG in connection with its evaluation of recruitment packages that fail to fall within the Safe Harbor.

Background Facts. The recruiting hospital was located in a rural area that was designated as an MUA. The hospital's needs analysis identified a shortage of physicians specializing in otolaryngology ("Specialty") in the hospital's service area. In an effort to recruit a Specialty physician to the hospital's service area, the hospital desired to loan funds to facilitate the physician's participation in a five-year Specialty residency program, which was conducted by an independent institution located more than 100 miles from the hospital.

The amount of the desired loan would be equal to the amount of the recruited physician's medical school loan payments required to be made by the physician during the 5-year residency program, and an additional amount to be used by the physician for other educational expenses. In exchange for the loan, the physician agreed to establish and maintain a full-time practice in the hospital's service area following completion of the residency program. The interest rate on the loan was anticipated at prime plus 1%, repayable in 3 annual installments commencing 1-year after the physician's completion of the residency program. The loan, however, would be incrementally forgiven by 1/3 for each year that the physician fulfilled his/her 3-year commitment to maintain a practice in the hospital's service area following his/her completion of the Specialty residency program.

Factors. In analyzing the proposed arrangement, the OIG recognized that relocation subsidies may be motivated in part by an improper intent to induce referrals in violation of the Antikickback Statute. The OIG, however, also acknowledged that the provision of such incentives may be necessary to attract medical professionals in many rural and urban underserved communities and that not all appropriate recruitment arrangements are capable of falling within the Safe Harbor requirements. Accordingly, the OIG recognized the need to evaluate recruitment arrangements that fail to fall within the safe harbor on a case-by-case basis, and identified the following factors to be considered:

1. Whether there is documented evidence of an objective need for the practitioner's services. The OIG recognized that recruitment activities designed to fulfill an objective need for services are "less suspect" than recruitment activities that attract a practitioner to an area that has no such shortages or need for services.
2. Whether the practitioner has an existing stream of referrals within the recruiting entity's service area. The OIG noted that the risk of abuse is minimized where a practitioner does not have "established referral streams that can be locked up through inappropriate incentives and loyalties."
3. Whether the benefit is narrowly tailored so that it does not exceed that which is reasonably necessary to recruit a practitioner. The OIG noted that whether the value or duration of a benefit is indicative of abusive practices varies based upon numerous factors, such as whether there is a reasonable and documented basis for the benefit's value and duration, and that generally, benefits provided over more than a 3-year period are suspect.
4. Whether the remuneration directly or indirectly benefits other referral sources. The payment of recruitment incentives to an existing referral source (*e.g.*, an existing medical group) will be "subject to a higher degree of scrutiny to ensure that the remuneration is not a disguised payment for past or future referrals."

OIG Analysis. The OIG recognized that the proposed arrangement implicated the Antikickback Statute and failed to satisfy the Safe Harbor requirements related to: (1) the recruitment of a practitioner to a HPSA; and (2) a 3-year limitation on the benefit period. In spite of these failures, the OIG concluded that the arrangement posed a minimal risk of fraud and abuse and determined that the hospital should not be subject to sanctions for violations of the Antikickback Statute. In support of its position, the OIG emphasized:

1. The hospital's objective documentation regarding the shortage of medical services in the hospital's service area;
2. The absence of an existing referral stream following the physician;
3. The payment of benefits directly to the physician (rather than to an existing referral source); and
4. The compliance with various other standards set forth under the safe harbor, including: (a) the physician will not be obligated to make or otherwise influence referrals to the hospital; (b) the physician will be free to establish staff privileges at and refer business to any other entity; and (c) the amounts paid by the hospital will not vary based on the volume of referrals to the hospital.

The guidance and insight provided in the Opinion should be applied to all physician recruiting arrangements that fall outside the Safe Harbor. It should be noted as well that the OIG Opinion is not binding on other government agencies and that it addresses only the statutory implications arising with respect to the recruitment arrangement under the Antikickback Statute. Accordingly, it will continue to be necessary to assure that all recruitment incentives are compliant with the Stark Law, and that all incentives provided by tax-exempt organizations meet the requirements imposed by the Internal Revenue Service. (*The Opinion is located on the OIG's website at <http://oig.hhs.gov/fraud/advisoryopinions/opinions.html#2>.*)

MEDICAL RESIDENTS FILE CLASS ACTION LAWSUIT ALLEGING ANTITRUST VIOLATIONS

By: Ann T. Hollenbeck

A lawsuit representing a potential class of approximately 200,000 medical residents was filed in the U.S. District Court for the District of Columbia on May 7, 2002, against seven medical groups, including the Association of American Medical Colleges (AAMC), the National Resident Matching Program (NRMP), the American Medical Association (AMA), the American Hospital Association and 27 teaching hospitals, including NRMP institutional participants and numerous prestigious AAMC member hospitals such as Yale, Duke and Georgetown. (*Jung v. Association of American Medical Colleges*, D.D.C.). The lawsuit was filed by 3 named plaintiffs and on behalf of all persons employed as resident physicians in Accreditation Council for Graduate Medical Education (ACGME) accredited residency programs, including fellowships programs, since May 7, 1998.

The plaintiffs contend that the NRMP, which places approximately 80% of first-year medical residents each year, is an unlawful restraint of trade and anticompetitive because it removes all bargaining power from medical residents and keeps wages low (reportedly under \$40,000 per

year) and hours long (reportedly over 100 hours per week). The complaint alleges that competition is restrained by: (1) the assignment by the NRMP of each medical resident to a specific, mandatory employment position through the NRMP system; (2) the exchange of detailed salary information and other terms of employment between medical resident employers, which results in the artificial depression and standardization of wages; and (3) defendants' compliance with the anti-competitive rules and regulations of the ACGME, which accredits and regulates the residency programs.

The complaint charges: "Employers pay residents standardized salaries, regardless of such factors as program prestige, medical specialty, geographic location, resident merit and year of employment....With few exceptions, employers pay salaries very close to the national average and very close to each other. By contrast, post-residency physicians earn widely varying compensation based on these factors, especially geographic location and medical specialty."

The complaint seeks injunctive relief to end the alleged illegal restraints, as well as money damages, which may be trebled under the antitrust laws. Under this class action, the defendants are jointly and severally liable for any and all damages that may be awarded to members of the plaintiff class. The potential exposure to any one defendant is considerable given the estimated size of the plaintiff class. Further, this class action raises significant issues for the AAMC, NRMP and their members and participants, respectively, and challenges the future of the graduate medical education placement process, which has operated for over the last 50 years to place medical residents in teaching hospitals across the nation.

The NRMP was created in 1953 to establish a more orderly system for matching residents with training opportunities. Previously, residency programs vigorously competed for residents, often beginning recruitment during a future resident's second year of medical school. The "free agent" manner in which residency programs were filled often resulted in last minute bidding wars for residents and unfilled training spots for many hospitals. The NRMP was created to remedy these inefficiencies. Today the NRMP matches approximately 16,000 U.S. medical students to 23,000 available residencies. Remaining spots are typically filled by foreign medical graduates. These procompetitive effects of bringing together hospitals and residents will certainly be argued by the defense.

On September 9, 2002, the AAMC filed a motion to dismiss the lawsuit arguing that, even assuming that everything the plaintiffs allege is true, the plaintiffs have failed to identify any wrongdoing on the part of the AAMC.

We will be monitoring all developments related to this case, and will provide updated information as it becomes available.

ACGME APPROVES PLAN TO LIMIT RESIDENT WORK HOURS

By: Ann T. Hollenbeck

In response to concerns that sleep deprivation could have a negative effect on resident and patient safety and resident education, the Accreditation Council for Graduate Medical Education ("ACGME," which accredits over 7,800 graduate medical education programs in 118 specialties) appointed the Work Group on Resident Duty Hours and the Learning Environment in September 2001. The Work Group consists of 16 individuals representing training programs from around the United States. In June 2002, the ACGME approved the standards suggested by

the Work Group in its written report (the "Report," which is available at <http://www.acgme.org/new/residentHours602.asp>).

The Report

The stated goal of the Report is to emphasize the responsibilities of residency programs and sponsoring institutions to ensure patient safety, quality care and an appropriate learning environment for medical residents. The Work Group acknowledges that the standards are "far-reaching," but emphasizes its view that the "only way residency programs and their sponsoring institutions can achieve a true 'education' program as well as provide high quality clinical care, is by attending to the issue of resident duty hours and placing a higher value on resident education and safe patient care than on meeting service demands."

The standards set forth in the Report provide: (1) minimum standards that must be met by all ACGME accredited programs; (2) requirements for institutional oversight and support; and (3) a strengthened system for compliance.

1. Minimum Standards.

The minimum standards focus on duty hours:

- Residents must not be scheduled for more than 80 duty hours per week, averaged over a four-week period, with the provision that individual programs may apply to their sponsoring institution's Graduate Medical Education Committee (GMEC) for an increase in this limit of up to 10%, if they can provide a sound educational rationale;
- One day in seven free of patient care responsibilities, averaged over a four-week period;
- Call no more frequently than every third night, averaged over a four-week period;
- A 24-hour limit on on-call duty, with an added period of up to 6 hours for continuity and transfer of care, educational debriefing and didactic activities, but no new patients may be accepted after 24 hours;
- A 10-hour minimum rest period between duty periods; and
- When residents take call from home and are called into the hospital, the time spent in the hospital must be counted toward the weekly duty hour limit.

2. Institutional Oversight: Requirements and Focus on High-Quality Education/Patient Care.

- Requiring a sound educational justification of any increases above the 80-hour limit;
- Monitoring of program policies governing resident duty hours by the sponsoring institution;
- An annual report to the sponsoring institution's governing body on duty hour compliance;
- Institutional policies on patient care activities external to the educational program (moonlighting), prospective approval of these activities, and monitoring their effect on performance in the educational program;
- Counting time spent in patient care activities external to the educational program that occur in the primary program and institution toward the weekly duty hour limit;
- Requiring programs and their sponsoring institutions to have policies and procedures to monitor and support the physical and emotional well being of residents;

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- Requiring sponsoring institutions to monitor the demands home call places on residents in all programs, and making adjustments as necessary to address excessive demands and fatigue;
- Patient care support services for IV, phlebotomy and transport activities to reduce resident time spent on these routine activities;
- Priority of clinical and didactic education in the allotment of residents' time and energies;
- Schedules for teaching staff structured to provide ready supervision and faculty support/consultation to residents on duty;
- Duty hour assignments that recognize faculty and residents collectively have responsibility for patients' safety and welfare;
- Monitor residents for the effects of sleep loss and fatigue by the residency program director and faculty, with appropriate action when it is determined that fatigue might affect patient care or learning;
- Education of faculty and residents in recognizing the signs of fatigue and in applying preventive and operational countermeasures; and
- Appropriate backup support when patient care responsibilities are difficult and prolonged, and if unexpected needs create resident fatigue sufficient to jeopardize patient care.

In the event a program believes it cannot meet these standards, an exemption beyond the 10% increase may be granted by a sponsoring institution to a particular specialty, but only upon: (i) the approval of both the ACGME Program Requirements Committee and the ACGME Board of Directors; and (ii) if the specialty can demonstrate that implementation of the standards would create a significant detrimental effect on clinical training and education.

3. *Strengthening the Systems for Compliance.*

The "enhanced system for promoting compliance" includes:

- Collecting comprehensive, uniform information related to duty hour compliance;
- Significantly shortening the review cycles for programs and sponsoring institutions that fail to comply with the duty hour standards;
- Use of an expedited institutional review process for potential serious violations or continued failure to comply by a program or a sponsoring institution, with the threat of withdrawal of accreditation from all accredited programs sponsored by the institution;
- Invoking the ACGME procedure for Rapid Response to Alleged Egregious Accreditation Violations or Catastrophic Institutional Events for serious duty hour violations; and
- Monitoring the ACGME's compliance activities to ensure consistent enforcement of the standards through increased training of site visitors, concurrent monitoring of the data on duty hours and the compliance process by a dedicated ACGME Subcommittee on Resident Duty Hours, and retrospective review of the Residency Review Committee's ("RRC") practices by the ACGME Monitoring Committee.

The Work Group emphasizes that the new standards must be implemented "without delay"; however, to accommodate residency programs and sponsoring institutions in the implementation of these standards, they will not be effective until July 1, 2003. The period until July 1, 2003 will be an "initial response" period, during which RRCs will provide constructive feedback on duty hours, but will not take adverse accreditation action.

The Work Group recognizes that the new standards will necessitate

adjustments in many residency programs and sponsoring institutions and states: "It would be disingenuous to understate the added costs of these changes, or the challenge that securing the added funds will present for many sponsoring institutions. The costs are real, but they are justified by the enhanced promotion of safe patient care, resident well-being and educational goals." The Report maintains that the ACGME will monitor the financial and operational hardships resulting from implementation of the new standards, and will report these hardships to its Board of Directors, member organizations and federal entities.

Industry Reaction

The Committee on Interns and Residents, a union representing more than 100,000 medical residents, praised the standards, but expressed concern that enforcement of the standards would be a problem absent federal legislation addressing the issue. The President of the Association of American Medical Colleges, Jordan J. Cohen, also praised the standards: "Putting these standards into action will help us achieve one of our most solemn professional obligations: providing our residents with an education of the highest quality, while protecting the patients they care for."

As further developments follow, we will provide additional information on this subject.

PROPOSED IRS REGULATIONS MAY LIMIT TAX-EXEMPT ORGANIZATIONS' USE OF NONQUALIFIED STOCK OPTIONS FOR EXECUTIVE COMPENSATION

By: Zachary A. Fryer

The IRS recently issued proposed regulations that would clarify and modify the treatment of certain deferred compensation plans under Section 457 of the Internal Revenue Code of 1986, as amended (the "Code"). Section 457 applies to certain deferred compensation plans of both state and local government entities and tax-exempt organizations.

Of particular interest to many tax-exempt organizations, the proposed regulations provide guidance regarding certain types of executive compensation plans of tax-exempt entities that have been assumed not to be subject to Section 457. These executive compensation plans include so-called "option programs" that provide discounted options on securities, such as mutual funds, to participating employees. Tax-exempt employers offering these plans have previously assumed that the transfer of discounted options or similar property as deferred compensation to participating employees will not fall within Section 457(f)'s ineligible plan rules, as they were covered under Section 83, which allowed the deferral of taxes until the option was exercised. Under the new Section 457(f) rules, Section 457(f) will not apply to a transfer if Section 83 applies to the transfer, but Section 457(f) will apply if the date on which there is a transfer of property to which Section 83 would apply is after the date on which there is no substantial risk of forfeiture. In other words, deferred compensation provided to an employee will be immediately taxable to the employee as soon as it is not "subject to a substantial risk of forfeiture."

The guidance in the proposed regulations indicates that where the discounted options or other deferred compensation amounts are not "subject to a substantial risk of forfeiture" at the time they are transferred, the executive compensation plan may nevertheless be treated as an "ineligible" plan under Code Section 457(f) and the transferred property included in a participant's taxable income. This may cause many tax-exempt nonprofit employers to cease the popular practice of using nonqualified stock options as deferred compensation to help attract and retain key employees.

SPEAKING ENGAGEMENTS

HMS&C Attorneys frequently are asked to speak at conferences and seminars. A calendar of upcoming speaking engagements is provided below.

Topic	Date(s)	Location	Speaker(s)
HSBC Insurance Management Captive Conference: "Captive Structure and Tax Considerations"	October 9, 2002	New York, NY	Julie E. Robertson
Health Financial Management Association 49 th Annual Fall Conference "HIPAA Implications for Patient Account Managers"	October 17, 2002	Ypsilanti, MI	Linda S. Ross
Michigan Health and Hospital Association Senior Executive HIPAA Summit - "HIPAA - Real World Strategies to HIPAA Compliance"	October 22, 2002	Lansing, MI	Linda S. Ross
American Health Lawyers Association 28 th Annual Tax Issues in Nonprofit Health Care Organizations Seminar: "Tax Exemption Standards for HMOs"	October 28-29, 2002	New Orleans, LA	Gerald M. Griffith
Central Mountain, Great Lakes and Gulf Coast Area TE/GE Councils (Exempt Organizations Group) Joint Annual Meeting "Update on St. David's and Whole Hospital Joint Ventures"	November 8, 2002	Washington, D.C.	Gerald M. Griffith
Michigan Association for Health Care Philanthropy - "The Intersection of HIPAA and Michigan Law in the Context of Fundraising"	November 15, 2002	Novi, MI	Linda S. Ross
IBC 8 th Annual Executive Forum On Captives: "Understanding Captives-Getting the Basics Right"	December 10, 2002	Cayman Islands	William M. Cassetta
IBC 8 th Annual Executive Forum On Captives: "Establishing Physician Captives - Challenges and Solutions"	December 12, 2002	Cayman Islands	Julie E. Robertson
Ninth Annual Michigan Health Law Institute (ICLE Seminar): "Advanced Tax-Exempt Issues"	March 6-7, 2003	Troy, MI	Gerald M. Griffith

Honigman Miller Schwartz and Cohn is a general practice law firm headquartered in Detroit, with an additional offices in Bingham Farms and Lansing, Michigan. Honigman Miller's staff of approximately 186 attorneys and more than 300 support personnel serves thousands of clients regionally, nationally and internationally. Our health care department includes the sixteen attorneys listed below who practice health care law on a full-time or substantially full-time basis, and a number of other attorneys who practice health care law part-time. Except as denoted below, attorneys in the health care department are licensed to practice law in the State of Michigan only.

William M. Cassetta	Patrick G. LePine	Linda S. Ross
Zachary A. Fryer	Stuart M. Lockman*	Chris E. Rossman
Gerald M. Griffith	Michael J. Philbrick	Valerie S. Rup
William O. Hochkammer	Cynthia F. Reaves****	Julie M. Schuetze***
Ann T. Hollenbeck	Julie E. Robertson**	Margaret A. Shannon
Carey F. Kalmowitz		

- * Licensed to practice law in Michigan and Florida, Florida board certified health law specialist.
- ** Licensed to practice law in Michigan and Ohio.
- *** Licensed to practice law in Michigan, Washington, DC and Massachusetts.
- **** Licensed to practice law in Michigan and Washington, DC.

For further information regarding any of the matters discussed in this newsletter, or a brochure that more specifically describes our practice in health care law, please feel free to contact any of the attorneys listed above at our Detroit office by calling (313) 465-7000.

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Honigman Miller Schwartz and Cohn also publishes newsletters concerning antitrust, employee benefits, employment, environmental and tax matters. If you would like further information regarding these publications, please contact Lee Ann Jones at (313) 465-7224, via e-mail at ljones@honigman.com, or visit the Honigman Miller Schwartz and Cohn web site at www.honigman.com.