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Health System Settles Case on Free CME; It Self-Disclosed After Internal Review

By Nina Youngstrom

Free continuing medical education (CME) and meals for physicians are at the heart of a Missouri academic health system's settlement with the HHS Office of Inspector General (OIG). As a "sleeper compliance issue," CME is ripe for oversight from compliance officers at hospitals that provide it to referring physicians, an attorney said.

The Curators of the University of Missouri on behalf of University of Missouri Health Care and University Physicians (the "respondent") agreed to pay $100,000 in the settlement. OIG alleged that from July 1, 2015, through July 30, 2021, respondent provided remuneration to 102 community physicians in the form of free CME and meals. OIG alleged the freebies violated the civil monetary penalty provisions applicable to the Anti-Kickback Statute and Stark Law, according to the settlement, which was obtained through the Freedom of Information Act.

The settlement stemmed from a self-disclosure to OIG by the University of Missouri Health Care and University Physicians, which was accepted to the Self-Disclosure Protocol on Jan. 21, 2022. The CME issue came to light after MU Health Care, as University of Missouri Health Care is known locally, "initiated an internal review of the program," Eric Maze, a spokesperson for MU Health Care, told *RMC*. "MU Health Care historically arranged CMEs from time to time to educate external providers on specific medical practices and issues, many related to our trauma, stroke or STEMI [ST elevation myocardial infarction] services. In some cases, MU Health Care is required to provide training and education as part of an accreditation process," he explained. "Boxed-type lunches were provided at some of the sessions at no cost, which was contrary to MU Health Care policy." Moving forward, the academic health system "will no longer sponsor CME sessions unless a fair market value charge is paid by outside providers attending." Maze noted that as soon as MU Health Care identified the CME concerns, staff received further training.

Compliance officers may want to look at CME. "It's a huge struggle in every hospital," said attorney Bob Wade, with Nelson Mullins in Nashville, Tennessee. "Their medical staff goes off and does their thing and sometimes there is little oversight between the medical staff department and legal or compliance departments." Although CMS has warned that CME could be remuneration under the Stark Law, hospitals have nothing to worry about with respect to employed physicians. CME for independent physicians is another story, but there are ways to do it compliantly, Wade said. Having them pay in advance may be preferable. For example, Wade said he helped one hospital build CME expenses into the medical staff dues of all physicians on the hospital's medical staff.

From the Wayback Machine: Stark Nixes Free CME

The reason free CME is potentially a problem under the Stark Law is because it creates a financial relationship with referring physicians that could taint Medicare reimbursement for all services referred to the hospital by the physicians, unless a compensation exception applies, Wade said. The Anti-Kickback Statute also could be implicated because it prohibits the knowing payment of remuneration to induce or reward the referrals of services paid by federal health care programs.

CMS cautioned hospitals about the risks of free CME in the 2005 Stark regulation (known as phase II), Wade said.[1] As CMS explained, free CME "could constitute remuneration to the physician, depending on the content of the program and the physician's obligation to acquire CME credits." CMS also refused to include CME in its definition of compliance training for purposes of meeting the compliance training exception, which is related to the exception for compensation arrangements.

To avoid running afoul of the Stark Law with free CME, hospitals should look to compensation exceptions, Wade said. Right off the bat, hospitals get a pass if they provide CME to employed physicians. In fact, if the physician is required to attend CME, the hospital can hold the training offsite and provide food. "You can sweep all the CME under the bona fide employment exception," Wade noted. It doesn't have to be put in writing. "You don't even need an employment agreement under the employment exception," he said.

Things get thornier with independent (nonemployed) physicians. "The real focus in your compliance and legal analysis is on your independent physicians," he said. It's possible the CME will be "embedded" in another arrangement the hospital has with the physician, such as a medical directorship, which is fine if the compensation accounts for the CME and is fair market value, but this configuration is rare, Wade said.

If using a contract to cover the CME, "you have to specifically call that out in the independent contract agreements," he noted. Using this method, the CME must satisfy the fair-market value or personal services arrangements exceptions to the Stark Law, which require the CME to be memorialized within the larger contract and the amount hospitals will pay for CME set forth in advance.

The analysis doesn't end there. Stark compliance is affected by additional variables for independent physicians when the CME is not covered by a written agreement:

- If CME is provided to the medical staff outside the hospital (e.g., at a hotel conference room with food and beverages), the hospital must account for the cost of renting the space and providing meals under Stark's nonmonetary compensation exception, which in 2022 is capped at $452 per physician, Wade said. The nonmonetary compensation exception allows hospitals to provide referring physicians noncash perks, such as dinners and tickets to sporting events, if they don't exceed the cap. It's probably relatively simple to allocate the cost of the meals, but the value of the CME is harder to pin down, he said. One option, which he frowns on, is to base the amount on what the physician would otherwise pay a third party for CME. "I think that's the wrong way to look at it from a fair market value perspective because hospitals, when providing CME, do it differently than a third-party company, which is out to make a profit," Wade said. The other option, which he prefers, is to use all direct and indirect costs associated with the CME event and divide the costs by the number of attendees or the average number of participants who usually attend the hospital's CME offering. "Then you can allocate that dollar amount to each attendee" and plug it into the nonmonetary compensation calculator, he said.

- If the free CME is provided inside the hospital, it possibly can apply Stark's medical staff incidental benefits exception. The exception allows hospitals to provide $39 of noncash benefits (usually meals and education) to each member of the medical staff per event an unlimited number of times, Wade said (the dollar amount is adjusted every year). "If you have CME, you go through the same analysis," he said. Hospitals would determine the value of a particular CME session, including refreshments, and "hopefully you come up with an amount per physician per benefit, meals separate from CME value, that's less than $39." Because the medical staff incidental benefits exception offers flexibility, "I encourage hospitals not to have CME outside the walls of the hospital unless they can meet another exception," Wade said.

Another Way: Adding CME Costs to Dues

When a hospital "didn't want to get into the conundrum of tracking all this stuff," Wade worked with it to instead build CME costs into the medical staff dues paid by all physicians. "We looked at the costs associated with the hospital offering CME annually," divided it by the number of medical staff members and increased medical staff dues by that amount, he said. Now all medical staff members are paying the hospital to put on CME. If the hospital ensures the increase in medical staff dues covers all anticipated CME costs, including small honorariums for speakers, "then it doesn't matter where it's offered—inside or outside the hospital—because the physicians are paying for it," Wade said.

The catch: the hospital and physicians must anticipate the CME costs and budget accordingly. "If we had set aside $100,000 for CME," he said, using a hypothetical number, "it would be a bad compliance issue if it ended up being $500,000." Stark's requirement for memorializing the terms of a compensation agreement is covered because members of the medical staff sign their applications and reapplications for the medical staff, Wade noted.

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1 Medicare Program; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase II), 69 Fed. Reg. 16,054 (March 26, 2004), http://bit.ly/3EMHkP7.