THE NEW YEAR RINGS IN STARK LAW CHANGES FOR GROUP PRACTICE COMPENSATION

Hodgson Russ Healthcare Alert
January 6, 2022

Effective January 1, 2022, new rules under the Medicare physician self-referral law (the Stark Law) came into effect regarding profit allocations for a group practice. These rules are part of a series of revisions intended to reduce regulatory burden and dismantle barriers to value-based care, while protecting the integrity of the Medicare program. Other aspects of these reforms went into effect on January 19, 2021, as discussed in our previous alert here.

The Stark Law generally prohibits physicians from referring Medicare patients to an entity for designated health services (DHS), if the physician or the physician's immediate family has a financial relationship with the entity.[1] Over the years, the Centers for Medicare and Medicaid Services (CMS) and the Office of the Inspector General have interpreted the Stark Law in a series of regulations and publications. The changes currently taking effect, available to view here, involve the group practice exception.

The most significant changes relate to the group practice compensation rules for sharing value-based profits, the definition of the term "overall profits" for distributing profits from DHS to physicians; and the rules for distributing productivity bonuses, as summarized below.

Value-Based Profit Shares

Under the revised rule, a group practice may distribute "profits from DHS that are directly attributable to a physician's participation in a value-based enterprise" to the participating physician, and such remuneration will be deemed not to be based on (or take into account) the volume or value of the physician's referrals under § 411.352(g). This change is intended to support the transition from a volume-based to a value-based health care system that reimburses providers based on the quality of services delivered rather than quantity. There was concern that the prior group practice rules could conflict with CMS's policy of encouraging value-based health care delivery models. The revised rule should mitigate any potential conflict.

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Defining "Overall Profits"

Under the prior rules, some group practices distributed profits from DHS, under a practice, known as split-pooling, on a service-by-service basis to subsets of physicians, and physicians could share in more than one profit-sharing pool at a time. Previously, in the Phase I Stark rules issued in 2001, CMS had interpreted the term "share of overall profits" to mean "a share of the entire profits of the entire group or any component of the group that consists of at least five physicians derived from DHS."[2]

Under the revised rule, CMS clarifies that "overall profits" means "the profits derived from ***all the*** DHS of any component of the group that consists of at least five physicians, which may include all physicians in the group" (emphasis added). In the commentary, CMS explains that it added the words "all the" before DHS to highlight the requirement that the group must aggregate the profits from all DHS of any component of a group consisting of at least five physicians (which may include all physicians in the group), before distributing them, rather than distributing profits from DHS on a service-by-service basis.

Under the revised rule, a group practice may designate more than one component of at least five physicians for the allocation of overall profits from DHS, so long as the formula aggregates ***all the*** profits from DHS referred by the physicians in a component and those physicians share in the profits from that component. In CMS's view, "a threshold of at least five physicians is likely to be broad enough to attenuate the ties between compensation and referrals of DHS." If the practice has fewer than five physicians, the group would need to aggregate profits from all DHS before distributing them among group physicians.

To illustrate, CMS provides the following hypothetical:

> assume a group practice comprised of 15 physicians furnishes clinical laboratory services, diagnostic imaging services and radiation oncology services. Assume further that the group practice has divided its physicians into three components of five physicians (component A, component B, and component C) for purposes of distributing the overall profits from the designated services of the practice. Under the final regulations, for each component, the group practice must aggregate the profits from all the designated health services furnished by the group and referred by any of the five physicians in the component.

85 Fed. Reg. 77492, 77566.

> Under this hypothetical, the group practice may distribute the overall profits from all the DHS within a component of at least five physicians using the same compliant methodology (for example, personal productivity methodology for non-DHS services in compliance with 42 C.F.R. § 411.352(i)(iii)(B) or a per capita-distribution methodology where profits are distributed per physician in the group). Among different components, the group practice may use different compliant profit allocation methodologies. Nevertheless, given the requirement that "all the" profits from DHS in any component be distributed within the same component of the group practice, it appears to be not possible for physicians to participate in multiple profit-sharing pools involving different practice group components.

Productivity Bonuses

The changes also clarify the rules relating to productivity bonuses. In the commentary, CMS explained that the question whether a physician may receive a productivity bonus based on services the physician or physician's care team personally performed (so long as the productivity bonus is not determined in a manner directly related to the volume or value of the physician's referrals of DHS) depends on the basis for the productivity bonus. Thus,

- a productivity bonus based solely on a physician's personally performed services would not violate the prohibition compensation based on the volume or value of a physician's referrals in § 411.352(g), because personally performed services, even for DHS, are not referrals;
- a productivity bonus based solely on non-DHS performed by a member of the physician's care team would not violate § 411.352(g);
- a productivity bonus based solely on DHS that a physician ordered and members of the physician's team furnished "incident to" the physician's services and billed as such to Medicare, would not violate § 411.352(g); and
- a productivity bonus based solely on DHS the physician ordered and members of the physician's care team furnished, but not "incident to" the physician's services, may relate only indirectly to the volume or value of the physician's referrals for the DHS the members of the physician's care team furnished.[3]

According to the rulemaking, the revisions relating to productivity bonuses are not intended to limit the payment of productivity bonuses currently permissible under the regulations.

Implications

Group practices, if they have not done so already, should revisit their policies on profit shares and productivity bonuses to evaluate compliance with the revised rules now in effect. Noncompliance with the Stark Law could result in a denial of payment or an obligation to repay a payment, as well as the imposition of civil monetary penalties for each non-compliant profit-sharing arrangement. The new rules should make it easier for group practices to participate in value-based arrangements with other health care entities. Additionally, reorganizing profits around all the DHS of a component of a group may provide opportunities for groups to distribute profits more equitably based on each component's similarities including practice patterns, tenure in practice, or location.

If you need assistance in analyzing or applying these changes in the context of current or prospective arrangements, please contact Jane Bello Burke (518.433.2404), Joshua Feinstein (716.848.1318), Roopa Chakkappan (716.848.1258), or any member of the Hodgson Russ Healthcare Practice.

[1] DHS includes clinical laboratory services; physical therapy, occupational therapy, and outpatient speech-language pathology services; radiology and other imaging services; radiation therapy services and supplies; durable medical equipment and supplies; parental and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. 42 C.F.R. § 411.351.

[2] Medicare and Medicaid Programs; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships, 66 Fed. Reg. 855, 908 (Jan. 4, 2001).

[3] *See* 42 C.F.R. § 411.352(i)(2) (conditions under which the physician's share of overall profits are deemed not to relate directly to the volume or value of referrals).