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Hospitals Face Big Stark Decisions on 'Under Arrangements,' Compensation

Time is running out for hospitals to comply with three major amendments to the Stark self-referral law that affect certain physician joint ventures and compensation methods.

Effective Oct. 1, most "under arrangements" will be prohibited, unless they provide lithotripsy. In a typical under arrangement, a physician entity (e.g., group practice) provides the soup-to-nuts of a hospital service — including the equipment, staff and management — but the patient belongs to the hospital and is billed to Medicare accordingly. The hospital then pays the physicians, who essentially function as subcontractors.

CMS also put an end to per-use ("per-click") fees for leased equipment or office space if the patients are referred by the hospital renting space to the physicians, or vice versa. Similarly, percentage-based compensation for equipment and space rentals will be verboten under Stark.

These three Stark restrictions were finalized in the 2009 inpatient prospective payment system (IPPS) regulation, which took effect October 2008, but CMS extended the compliance date. (Other Stark provisions in the IPPS rule took effect last year.) "There will be no wiggle room here, no grandfathering, no grace period," says Washington, D.C., attorney Lisa Ohrin, who helped write the amendments and Phase III of the Stark regulations as then-deputy director of the CMS Division of Technical Payment Policy.

Many hospitals have already unwound or restructured their under arrangements and fixed noncompliant compensation deals. For those that haven't, the surefire route to Stark safety as Oct. 1 approaches is to "stop referrals until you get on the side of compliance," Ohrin says. If your under arrangement is still in business and your hospital wants to find a way to keep some version of it viable, for now just don't accept referrals from physician-owners of the under-arrangement entity, says Ohrin, now with Sonnenschein Nath & Rosenthal.

CMS orchestrated the end of under arrangements by changing a key definition in the Stark law, which bans Medicare payment to entities that perform designated health services (DHS) stemming from referrals by physicians who have a financial relationship with the DHS entity. Prior to Oct. 1, 2009, only the entity that bills for DHS could run afoul of the law. That worked beautifully for under arrangements because the hospital does the billing while the physician entity (e.g., group practice, physician management organization) provides the services, which means referrals between them are protected. But starting Oct. 1, the physician entity triggers the Stark ban if it performs services (e.g., cardiac catheterization, open MRIs, nuclear cameras).

In the IPPS regulation, CMS intentionally did not define what it means to "perform" a service because it feared providers would claim any deviation from the definition meant they did not perform a service and therefore could continue an under arrangement. However, CMS states in the regulation that physicians "generally know when they have performed a service and when they are entitled to bill for it." CMS also asserts that an entity is *not* performing DHS when it "leases or sells space or equipment used for the performance of the service or furnishes supplies that are not separately billable but used in the performance of the medical service, or that provides management, billing services or personnel to the entity performing the service."

The fact that CMS spelled out only how the performance criteria are not met leaves the industry hanging, says attorney Alan Rumph, who is with Smith, Hawkins, Hollingsworth & Reeves in Macon, Ga. He considers CMS's anti-definition analogous to the famous U.S. Supreme Court decision, in which Justice Potter Stewart said it was extremely hard to define "obscenity," but "
you know it when you see it." That's hard to operationalize in the world of hospital-physician relationships, Rumph notes.

How to Fix 'Under Arrangements'

Take the case of under arrangements for diagnostic tests that require supervision. Would the physician-owned entity be able to provide everything in a space designated

by the hospital with the exception of physician supervision, which would be arranged by the hospital? The regulation's definition of "performance" might leave open a door to this kind of arrangement. But achieving an adequate comfort level may take either more guidance from CMS — which Ohrin says probably isn't coming soon — or a Stark advisory opinion. "It depends on your risk-aversion level," says attorney Al Shay, with Morgan Lewis & Bockius in Washington, D.C. Ohrin thinks the smart money is on entities that don't seem to "fly in the face of the prohibition" on under arrangements.

With the Oct. 1 deadline looming, hospitals have three choices when it comes to fixing their under arrangements, Ohrin says:

(1) Don't make referrals. That's the quick fix. It doesn't solve the problem of how to keep providing the services or generating revenue, but it's essential to Stark compliance and preventing Medicare from refusing to pay for services referred by physicians involved in the under arrangements.

(2) Don't have physicians as owners. "In many cases, physicians are selling the entity back to the hospital," she says. The sale must fit in a Stark exception (e.g., isolated transaction, fair-market value) because the physicians refer patients to the hospital for other outpatient and inpatient services. She has also seen for-profit groups convert to nonprofits so physicians are not owners anymore (nonprofits have members, not owners). There are a host of repercussions for groups that take this route, but it's being done.

(3) Don't be an entity. There are ways to accomplish this without crossing the line into performing the services, which triggers Stark on Oct. 1, she says. "You need to not perform to not be an entity," Ohrin explains. For example, the physician entity can lease equipment to the hospital under one Stark-compliant agreement and then provide staff, supplies and management under a separate Stark-compliant agreement. "Some people have concerns with this model because they feel all parts of the service are still coming from physicians, but as long as separate arrangements satisfy Stark, it changes the fundamental nature of the arrangement," she says. "That leaves the way the hospital furnishes services to patients as close to intact as possible. It's simple and clean." Ohrin and Shay emphasize that no per-click payments can be made under this arrangement. "CMS says a physician group can still lease equipment to the hospital, but if a member of that group generates the referral that requires the equipment to be used, [the physician] can't be paid on a per-use basis," Shay notes.

Possible Strategies for Per-Click Rentals

Stark bars per-click (per-use) rentals of office equipment and space only in one direction: There can't be a per-click payment that takes into account patients referred by the lessor to the lessee. "This was a common payment methodology, so it's a big change," Shay notes. For example, a hospital that uses its MRI only 60% of the time might rent it to a physician group on Tuesdays and Thursdays from 1 p.m. to 5 p.m. After Oct. 1, physicians can pay the hospital per-click rent only if the hospital doesn't refer any patients to the physicians, Rumph says. Or if the hospital wants to refer patients to these physicians on Tuesdays and Thursday afternoons, other Stark-approved payment methods must be used, such as flat fees or block fees (with the required four-hour minimum), Ohrin says.

Hospitals that do the math of before-and-after payments for services they are now leasing from physicians may be happy with this Stark crackdown, Ohrin notes. One hospital broke out the expenses of its under arrangement and found that the per-click payments to physicians totaled $180,000 a year for tests performed on the equipment they leased to the hospital instead of $40,000 that was the fair-market-value price for the equipment leased separately at a flat fee. "A lot of physician groups are upset they have to sell or rent [the equipment] at a fair-market flat fee. When they find out what it is, it doesn't come close to what the hospital was paying them using per-click methodology," Ohrin says.

Shay says hospitals will have to examine all of their equipment rental arrangements and office-space leases to determine if they need restructuring. "There are options here," Shay says. For example, hospitals that rent a nuclear camera from physicians may pay a flat monthly payment for the use of the equipment for patients referred by the lessor physicians, plus a per-service fee for use of the equipment to treat patients referred by other physicians, Shay says. It will be critical that the total lease payments made by the hospital for the nuclear camera meet all the requirements of the lease exception, including the fair-market-value requirement, he says.

Regardless of who refers the patient, DHS entities and physicians have to say goodbye to percentage compensation for office space and equipment leases, Rumph notes. However, the commentary in the Phase II Stark regulations, which CMS used in issuing an FAQ allowing per-click and percentage-based compensation in lithotripsy arrangements *(RMC 2/2/09, p. 1)*, may allow space or equipment leases to be subsumed within a more comprehensive service contract and avoid the per-click and percentage restrictions, he says. "Care must be taken that the comprehensive contract (other than for lithotripsy) does not run afoul of the new entity/under arrangement provision," Rumph cautions.

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