HEALTH CARE ISSUES

The Health Care Department at Murtha Cullina is pleased to provide clients and friends with information about topics of interest in the health care area.

If you have questions about the issues addressed in this newsletter, or any other matters involving health care legal issues, please feel free to contact the following attorneys:

Heather O. Berchem
Marcel J. Bernier
Frank M. Capezzera
Thomas M. Cloherty
Robert V. Giunta, Jr.
Anne Hanford
H. Kennedy Hudner
Paul E. Knag
Michael T. Kogut
Mark F. Korber
Kenneth L. Levine
Raj R. Mahale
Michael E. McDonough
Martha Everett Meng
Robert J. Munnelly, Jr.
Elizabeth Neuwirth
Stephen E. Ronai
Alfred E. Smith, Jr.
Stephanie E. Sprague
Midhat H. Syed
Joseph R. Tarby, III
Louis B. Todisco

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STARK III REGULATIONS:
SOME CHANGES, SEVERAL CLARIFICATIONS

Important Changes to Physician Recruitment and Calculation of Fair Market Value

The new Phase III Stark Regulations become effective December 4, 2007. For physicians and hospitals alike, this triggers the need to once again review any arrangements they have which are governed by Stark to make sure that they are in compliance and have adequate documentation.

1. Physician Recruiting

Perhaps one of the most sensitive issues for group practices has been recruiting new physicians with the help of the local hospital. The hospital gets a new physician in its service area. The group gets not only a new employee…but a potential competitor. One significant change made by the regulations is that Phase III now permits group practices to impose restrictions on a recruited physician so long as the restrictions do not unreasonably restrict the doctor’s ability to practice within the hospital’s service area. The issue of whether a restriction is “unreasonable” will be governed by state law, but this typically involves covenants-not-to-compete.

In Massachusetts, where covenants-not-to-compete are not allowed in physician employment agreements, this change may not be as significant. But in Connecticut, this is an important change. Connecticut law does allow reasonable non-competition restrictions, even for physicians. Because of the sensitive nature of physician-patient relations, the court will be
more likely to give physician non-compete provisions very careful scrutiny. These restrictions need to be carefully thought out and drafted to be enforceable.

There is one other important change concerning physician recruitment: the definition of the hospital’s service area. The recruited physician must relocate his or her practice to the hospital’s “service area.” Under Phase II, that was defined as the lowest number of contiguous zip codes from which the hospital draws at least 75% of its inpatients. Phase III expands “service area” so that if less than 75% of the hospital’s inpatients came from contiguous zip codes, then the service area would be all of the contiguous zip codes from which inpatients were drawn.

**What you should do:** If you are a group contemplating recruiting a new physician with assistance from the hospital, give serious consideration to a covenant not to compete.

2. **“Stand in the shoes” - New Indirect Compensation Regulations**

Another significant change has to do with the definition of indirect compensation. Under Phase III, each physician in a physician practice “stands in the shoes” of his or her “physician organization,” which might include a group practice, a physician practice or an entity in which the physician is the sole owner. This means that compensation arrangements that had previously been examined under the “indirect compensation” rules must now be judged under the direct compensation rules. Existing arrangements that satisfied the indirect compensation as of September 5, 2007 will be allowed to continue until the end of their current term (or current renewal term), even if that does not terminate until after the Phase III effective date of December 4, 2007. After that term, however, they must come into conformance with the new rule.

**What you should do:** If you are in a Stark arrangement based upon an indirect compensation exception, you need to carefully review the structure of your relationship under the new rules.

3. **In-Office Ancillary Services Exception**

The Stark rules permit multiple physician groups to share space in the same building for the purpose of sharing a clinical laboratory, imaging center or other facility that provides DHS to patients. An unresolved issue in this area is whether the physicians groups could *simultaneously* use the space and share the costs of administration, or whether each physician group had to *exclusively* control the space at any time they were using it. In an important clarification, CMS has made it clear that in order to satisfy the in-office ancillary services exception, “this likely necessitates a block-lease arrangement for the space and equipment used to provide the [services].” CMS then went on to say that the commonly employed per-use fees (including the much loved “per click” fees) are not likely to satisfy the supervision requirements of the in-office ancillary services exception.

Ominously, CMS noted that the OIG is presently reviewing whether in-office imaging and pathology services should continue to be eligible for the in-office ancillary exception.
CMS also reminded the health care industry that while some arrangements might meet CMS rules for Medicare assignments, that does not mean they are valid under Stark. Specifically, when independent contractor physicians are working for a group in an arrangement intended to satisfy the in-office exception, the independent contractor physicians must perform the work on the group’s premises, not off-site, even though the Medicare assignment rules allow off-site work.

**What you should do:** If you are in a multiple-use arrangement, check the terms to see if you have a block lease. If not, you need to amend the contract or terminate the arrangement.

4. **Physician in the Group Practice**

CMS also modified the definition of a “physician in the group practice.” It is now clear that each independent contractor physician must be under a contract directly between him or herself and the group. It is not sufficient to have a contract between the group and some entity that provides physicians to work at the group.

5. **Productivity Bonuses and Profit Shares**

One of the significant benefits of qualifying as a “group practice” is the flexibility it gives to the group in compensating its physicians. Under Phase II, Stark regulations allowed groups to pay physicians productivity bonuses and profit shares.

The Phase II regulations required that profit sharing or productivity bonuses be based on services that the physician personally performed, and further required that the profit share or bonus not be determined in a manner that is directly related to the volume or value of referrals of DHS by the physician. Unfortunately, the Phase II regulations were not clear on whether a productivity bonus could take into account the volume and value of items/services provided “incident to” the doctor’s professional services.

The Phase III amendments make it clear that productivity bonuses can be based directly on “incident to” services that are incidental to the physician’s personally performed services, even if they are designated as DHS services. For example, a doctor can be paid a product bonus based directly upon physical therapy services that are provided incident to his services. However, the productivity bonus cannot be directly related to other DHS referrals, such as diagnostic tests.

Further, CMS now says that overall profit shares may not be allocated in a manner that directly relates to DHS referrals, including a DHS billed as an “incident to” service.

**What you should do:** Groups that have profit sharing and/or productivity bonus schemes should review them carefully with their accountants before the end of the year.
6. Elimination of Hourly Payment Safe Harbor

Paying physicians for personal services has always been a thorny problem. To meet the Stark exception for personal services, the payment has to be at “fair market value.” But what is a fair market payment? In Phase II, CMS created a safe harbor which said that an hourly payment to a physician would be considered fair market if: (i) it was equal to the average hourly rate for emergency room physician services in the relevant physician market, or (ii) it averaged the 50th percentile salary for the physicians specialty of four national surveys specified by CMS, divided by 2000 hours.

This well-intentioned effort generated a storm of criticism. In Phase III, CMS now eliminates the safe harbor, but notes that it is nevertheless prudent to refer to multiple, objective, independently published salary surveys when determining fair market value.

What you should do: Don’t relax too much. The requirement that payments be at fair market value still remains. Although the safe harbor provided in Phase II was clunky and did not work very well, it was a yardstick by which to measure fair market value. Above all, resist the temptation to think that now that CMS has dropped the hourly salary safe harbor, the physician can be paid whatever you want. That is incorrect. You still need to be able to justify the fair market value of whatever price is paid, or run the risk that the arrangement will be held illegal.

Conclusion: If nothing else, the changes to the indirect compensation rule alone make it very clear that hospitals and other entities that bill Medicare must now employ a centralized listing, legal review and active management of contracts with referring physicians and physician groups. All compensation relationships with physicians should be re-evaluated to determine if, with the new “stands-in-the-shoes” rule, the contractual relationship needs to be changed.

If you have any questions about this bulletin or other health care regulatory matters, feel free to call Kennedy Hudner (860-240-6029), Paul Knag (203-653-5407), Elizabeth Neuworth (203-653-5411) or Mark Korber (860-240-6030).