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STARK III: *Refinement* NOT REVOLUTION (PART 2)

The regulations include good news for physicians who work with hospitals.

The Stark III regulations that went into effect on Dec. 4 include a number of developments that might significantly help family physicians.

Part one of this two-part series of articles addressed significant changes for physicians in group practices. (See "Stark III: Refinement Not Revolution (Part 1)," *FPM*, March 2008.) This article addresses issues tied to the relationships between physicians and the hospitals at which they attend and to which they refer.

Recruitment

The Stark statute protects hospitals that assist physicians relocating to the community with practice support, including an income guarantee. The "Stark II, Phase II" regulations published in 2004 made it clear that the hospital cannot require the recruited physician to refer patients to the facility.

Typically in these situations, a hospital provides the recruit with an income guarantee loan for a year while the recruited physician establishes a practice in the community. After a year's worth of support, the hospital forgives a portion of that loan for each month the physician stays in the community, so eventually no repayment is necessary. But if the physician leaves the community, the loan becomes immediately due.

In Phase II, the hospital was explicitly permitted to provide support to group practices that refer to the hospital when they recruited a physician to join them. In addition to providing the income guarantee, the hospital could pay for the costs of adding the physician to the practice. The addition of phone lines, furniture, cell phones, pagers, additional support staff dedicated to the new physician and the like were considered legitimate incremental costs. As generous as that seems, though, the Phase II regulations precluded the group from imposing any kind of practice restrictions on the recruit, including a restrictive covenant. This was extremely burdensome to groups in which every other physician must work under a geographic restriction following termination.

The Stark III regulations have removed this burden by explicitly permitting the group practice to do a number of things related to their recruits:

- Groups can restrict the recruit's right to moonlight;
- Groups can prohibit solicitation of their patients or employees if the recruited physician is terminated;
- Groups can prohibit the recruit from using their proprietary confidential information;
- Groups can require the recruit to repay losses that exceed the hospital's guarantee cap;
- Groups can even impose liquidated damages on the physician to buy out the covenant as long as the dollar amount is not punitive.

The group still cannot unreasonably restrict the recruit geographically, but the new provisions are far more palatable. In addition, support can be made available not

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This second article in a two-part series on the Stark III regulations discusses issues tied to relationships between physicians and hospitals.

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just for someone who is moving across the country, but also for someone who is leaving a residency or a fellowship, the military, or the Veterans Administration or the Indian Health Service. The agreement, however, must be signed by all three parties – the group, the recruit and the hospital.

Co-location and shared office space agreements, in which the recruit is not actually joining the group practice, do not provide a basis for the hospital to subsidize the group in any way. The hospital can still subsidize the recruit, who in turn may pay rent to a group practice landlord or buy administrative services from the group.

In cases where the recruit is an employee of the group, nothing precludes the hospital from imposing the financial burden of repayment on the group if the recruit breaches his or her contract. However, the group itself cannot indemnify the recruit for repayment because that will raise a potential anti-kickback statute problem.

Taken together, these changes are very helpful to groups seeking hospital assistance in recruiting physicians to join them.

Personal services arrangements

Under the Stark III regulations, hospitals can pay physicians fair market value for legitimate services they render on behalf of the hospital. Call coverage for the emergency department, for example, has now been recognized as a service physicians can be paid for, subject to certain protections, in an Office of the Inspector General advisory opinion. Physician service to the medical staff in leadership activities or in doing work on quality initiatives can also qualify.

Stark III eliminates an aspect of the regulatory definition of fair market value that primarily set hourly rates at the 50th percentile for the relevant specialty, based on data from the Medical Group Management Association. This approach was very restrictive. Now, under the personal services exception, the Centers for Medicare & Medicaid Services (CMS) has explicitly said that compensation related to achieving patient satisfaction goals or other quality measures unrelated to the volume or value of services generated by the physician, and unrelated to reducing or limiting services to patients, can be paid for under this exception. As a result, family physicians – even those who merely refer to the hospital – may be paid for the following types of work:

- Selecting clinical practice guidelines;
- Development of standing order sets;
- Choosing and implementing an electronic health record (EHR) system;
- Any of the activities associated with a hospital's participation in the Institute for Healthcare Improvement's "5 Million Lives" campaign.

Compliance training exception

The Phase II regulations allowed the hospital to pay for training for its medical staff members regarding "compliance." The breadth of the definition of compliance includes any federal or state legal requirements. Topics could include pay for performance under Medicare, the Physician Quality Reporting Initiative, clinical integration under the antitrust laws, false claims avoidance, development of physician office compliance programs including standardizing care in accordance with evidence-based medicine, use of clinical practice guidelines, appropriate referrals, effective documentation techniques including template-driven documentation, the highest and best use of physicians and nonphysician practitioners in accordance with payment and

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malpractice principles, malpractice avoidance, patient safety and even compliance with the Health Insurance Portability and Accountability Act's privacy and security rules. Not only can the sweep of this regulation help physicians in their daily practice lives, but the Stark III regulations also have added the ability of the hospital to offer continuing medical education credits for the training.

Electronic health records exception

In 2006, CMS published a safe harbor under the anti-kickback statute and an exception under the Stark statute for hospitals to donate to members of their medical staff software for EHRs and software and hardware for e-prescribing. The hospital can donate software to physicians, who in turn must pay 15 percent of the hospital's cost of the system. The Stark III regulations did nothing substantive to this safe harbor but did say that the "community-wide health information system" exception is being tabled pending results of the impact of the EHR exception. The big dilemma here is that while a hospital can donate these systems to physicians, it cannot replace systems that already exist in physician practices, even though the e-prescribing and EHR systems must be interoperable. Hospitals have done relatively little with this safe harbor so far, but we are beginning to see more activity.

Malpractice insurance subsidies

The 2006 anti-kickback statute did not allow a safe harbor for hospital subsidies of malpractice insurance costs unless the physicians were in an underserved area. However, as the nation's malpractice insurance crisis accelerated, the Department of Health and Human Services Office of the Inspector General recognized a time-limited broader exception for crisis states. The Stark regulations limit straight malpractice insurance subsidies to obstetrical services in rural areas. However, in response to comments, CMS has said in Stark III that the fair market value, bona fide employment and personal services arrangement exceptions can be used to provide hospital malpractice insurance subsidies if they are properly constructed. The fair-market value exception can now be used for payments to or from a physician. However, to merit compensation in the form of malpractice insurance subsidies, the physician must be doing or giving something to the hospital, such as volunteering in the hospital's clinic or teaching residents in his or her office. Under the bona fide employment exception, subsidies can be provided whether the physician works for the hospital full time or part time. The personal services exception can be used for services the physician performs on behalf of the hospital if the hospital bills for those services. Then the malpractice subsidy could qualify as fair-market value compensation.

Nonmonetary compensation

A hospital is permitted to give staff members nonmonetary compensation of up to $300 per year per physician, adjusted for inflation. The limit for 2008 is $338. The annual staff dinner, or a similar event for the entire medical staff, is excepted from this benefit. Protected nonmonetary compensation, however, may not be solicited by the physician or the physician's practice.

Medical staff incidental benefits

Under Stark III, the regulators have clarified that medical staff incidental benefits, such as parking, white-coat laundry, meals and pagers, may only be used on the hospital campus. This exception does protect devices used to communicate with patients or other personnel not on the hospital campus. It also allows hospitals to list a physician's name on its Web site or in advertisements, which amounts to free marketing for the physician. These incidental benefits must be offered to everyone on the staff equally, and each item must be of low value (less than $25).

Proceed with caution

The Stark III regulations provide clarifications and some significant liberalizations that can benefit family physicians. However, the level of detail in these regulations and, more significantly, in the CMS narrative explaining them, is fraught with pitfalls. Within groups and in relationships with hospitals, prudent family physicians should obtain appropriate guidance for all financial relationships associated with referrals for "designated health services." The best news may be that the list of designated health services is limited. FPM

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