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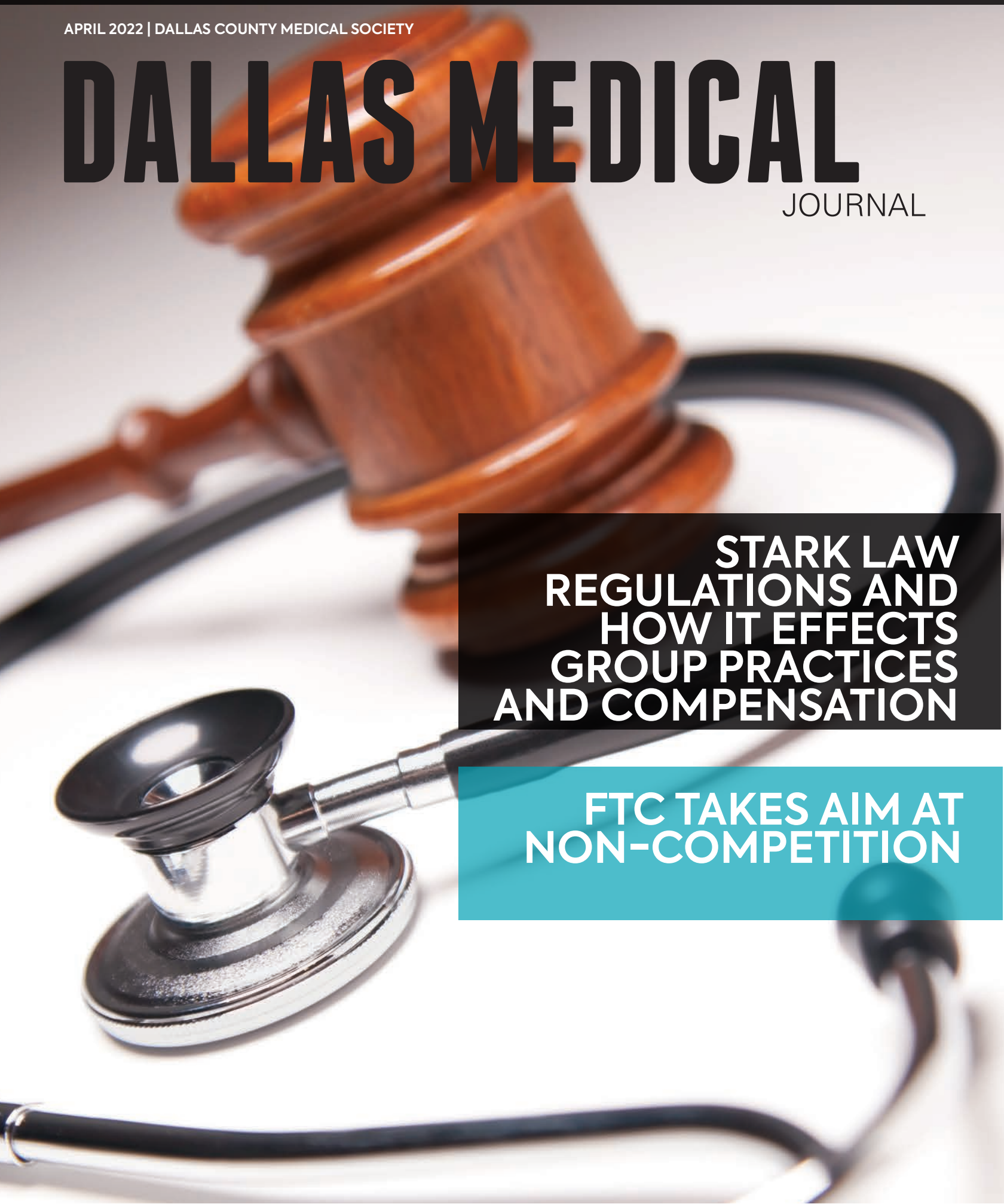
APRIL 2022 | DALLAS COUNTY MEDICAL SOCIETY

DALLAS MEDICAL JOURNAL



STARK LAW REGULATIONS AND HOW IT EFFECTS GROUP PRACTICES AND COMPENSATION

FTC TAKES AIM AT NON-COMPETITION

HOUSE CALL

DO NOT PASS GO

GO DIRECTLY TO YOUR COMPENSATION POLICY

By W. Darrell Armer and Rachel O. Poynter, Gray Reed

As part of its efforts to accelerate the transformation of the healthcare system, the U.S. Department of Health and Human Services ("HHS") launched its "Regulatory Sprint to Coordinated Care" and the Centers for Medicare & Medicaid Services ("CMS") released a number of final rules, including rules that changed the Physician Self-Referral Law (the "Stark Law") regulations. While the bulk of the final rules were focused on removing regulatory barriers to coordinated and value-based care, an important revision was made to the definition of "group practice," which directly impacts the compensation methodology that can be adopted by physician practices.

To qualify as a group practice under the Stark Law, there are nine detailed requirements that must be met. One of these requirements – profit shares and productivity bonuses – was significantly modified by CMS' regulations that went into effect on January 1, 2022. Satisfying these requirements is important because a physician practice that is a "group practice" may avail itself of certain exceptions to the Stark Law – most notably, the "in-office ancillary services" exception (the "IOAS Exception"), which allows group practices to provide and receive payment for the provision of designated health services ("DHS"). If a physician practice no longer satisfies the nine requirements to be considered a group practice, then the physician practice's receipt of payment for a physician's referrals of DHS to the practice are no longer protected. As such, if a group practice has not done so already, it must immediately ensure that its current compensation methodology does not run afoul of the Stark Law.

It has long been the rule that a group practice may pay a physician in the group a share of the "overall profits" so long as the payment is not directly related to the volume or value of the physician's referrals. However, CMS has now deviated from its previous definition of overall profits in a way that significantly impacts how profits may be distributed in a group practice. Specifically, overall profits now means the profits derived from all the DHS of any component of the group that consists of at least five physicians or, if there are less than five physicians in the group, the profits derived from all the DHS of the group. This change (i.e., the use of the phrase "all the DHS") is notable because CMS has made clear that a group practice may no longer pool and distribute profits from DHS on a service-by-service basis (also referred to as "split pooling"). The profits from all the DHS of any component of the group that consists of at least five physicians must be aggregated before distribution.

In rulemaking, CMS provided the example of a physician practice that provides both clinical laboratory services and diagnostic imaging services (both of which are DHS) to its patients in a centralized building. If the practice wishes to qualify as a group practice for purposes of the Stark Law, it may not distribute the profits from the clinical laboratory services to one subset of its physicians and distribute the profits from diagnostic imaging to another subset of physicians. Separate and apart from the aggregation requirement, CMS indicates that sharing profits on a service-by-service basis could also call into question whether a physician practice could satisfy other requirements of the group practice definition (for example, could the group practice still claim to be a unified business?).

Through this updated definition to overall profits, CMS has also clarified that a group practice is not required to treat all

components of at least five physicians the same in terms of the distribution of shares of overall profits from DHS. The group practice can utilize different distribution methodologies to distribute shares of overall profits from all of the DHS of each of its components of five or more physicians, so long as the group practice utilizes the same methodology for distributing overall profits for every physician within a single component. For example, in a group practice of 10 physicians that furnish both clinical laboratory services and diagnostic imaging services, the physicians can be divided into two components (Component 1 and Component 2) of five physicians for purposes of distributing the overall profits from the DHS of the group practice. Component 1 may distribute overall profits based on a per-capita distribution methodology, and Component 2 may distribute overall profits based on a personal productivity methodology. As noted above, though, a group practice could not use different methodologies to distribute the profits of the different types of DHS within a component. For example, Component 1 could not use a per-capita distribution methodology to distribute overall profits associated with diagnostic imaging services and then use a personal productivity methodology to distribute overall profits associated with clinical laboratory services. This differentiation within a component would constitute distributing profits on a service-by-service basis, which CMS has clarified is not permitted.

CMS does not place strict parameters around how a group practice establishes the components of at least five physicians. For example, physicians may be grouped by similar practice patterns, practice location, years of experience, similar tenure within the group practice, or other criteria determined by the practice. All that is essential is that the share of the overall profits received by the physician is not determined in any manner that is directly related to the volume or value of the physician's referrals.

Lastly, CMS made changes to align the special rules for profit shares and productivity bonuses with the new value-based rules. More specifically, CMS will allow a physician to be paid profits from DHS that are directly attributable to a physician's participation in a value-based enterprise.

It is important to remember that the foregoing only applies to overall profits and revenues derived from DHS. Group practices may still distribute the revenues from services that are not DHS in any manner that they wish. And lastly, practices should be prepared to provide supporting documentation verifying the method used to calculate the profit share or productivity bonus to the Secretary of CMS upon request.

Since the new regulations are now in effect, this is your last CHANCE. DO NOT PASS GO. Go directly to your compensation policy. And as long as it complies with the new rules, then YOU CAN LEGALLY COLLECT $200. **DMJ**

ABOUT THE AUTHORS

An experienced dealmaker and strategic advisor for a diverse group of healthcare clients, Darrell Armer focuses his practice on structuring complex commercial transactions that not only achieve his clients' business goals, but also minimize risk within strict regulatory frameworks. As leader of the Healthcare Transactions Practice Group, he has over 25 years of experience managing all aspects of the organization, reorganization, funding, operation, and merger/acquisition of a variety of providers, including hospitals, ambulatory surgery centers, physical therapy companies, diagnostic imaging centers, medical and dental practices, and home health agencies, as well as various provider networks. He is board certified in Health Law by the Texas Board of Legal Specialization. He can be reached at darmer@grayreed.com.

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