GRAY REED

Foot-Dragging on Stark Reform Leaves APMs at Risk, Slows Growth of Program

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Congressional foot-dragging on reform of Stark and other fraud-and-abuse laws may leave providers in alternative payment models (APMs) subject to penalties even if they're acting in good faith — which may be making the program too difficult for all but the richest entrants to attempt.

Those laws came back into provider focus with a March 21 hearing of the House Ways and Means Committee at which members of Congress questioned CMS officials about the Medicare Access and CHIP Reauthorization Act (MACRA). Rep. Kenny Marchant, R-Texas, brought up Stark, claiming doctors' and medical groups' "big complaint is they say that the Stark laws are creating real barriers to their coordination."

Marchant mentioned his bill — H.R. 4206, the Medicare Care Coordination Improvement Act — which has been before the House since 2017, that would essentially give the same exceptions to Stark and other such laws currently enjoyed by accountable care organizations (ACOs) to APMs — the experimental cost-sharing organizations that, when designated by CMS as "advanced APMs," provide an alternative to the merit-based incentive payment system (MIPS).

"Stark has a really big impact on how relationships are structured in the health care space," acknowledged CMS Principal Deputy Administrator Demetrios L. Kouzoukas. He mentioned President Donald Trump's January budget proposal, which contained a plan to "reform physician self-referral law to better support and align with alternative payment models and to address overutilization." However, that proposal was not addressed in the budget bill that became law last month (PBN blog 2/9/18).

Stark law is known to providers mainly for its prohibitions against self-referral — usually by means of referral to a party in which they have a financial interest — of designated health services (DHS). Unless such a referral is specifically excepted by Stark, as with the in-office ancillary service exception, it's usually against the law to give it.

No intent needed for Stark violation

With Stark, it doesn't matter whether the provider is willfully trying to cheat or just trying to do the right thing when he or she runs afoul of the law, says Darrell Armer, a partner in

Gray Reed & McGraw's health law section in Dallas. While other such laws — for example, the anti-kickback statute (AKS) — are intent-based so the intention of the provider in performing the act can be taken into account, "you simply do not have that flexibility with the Stark law," says Armer.

Stark law is made up of "essentially strict liability provisions in which the very act of making a prohibited referral is illegal, and the service rendered cannot be billed to Medicare," as Joel Dziengielewski, director of Navigant Consulting in New York, and Margaret J. Davino, an attorney with Kaufman Borgeest & Ryan LLP in New York, described it in their 2015 report, "Mergers and Acquisitions in Healthcare on the Rise: Legal and Compliance Issues." And because prohibited referrals should not be made under Medicare, any claim thus made would be a potential violation of the False Claims Act as well.

This makes Stark a landmine even for honest providers. "There may be no harm to public [treasury], no issue of fair market value — but if a hospital has an agreement with a physician that's supposed to be signed but isn't signed, for example, it is a violation," says Kathy H. Butler, officer and attorney in the Health Care Practice Group at Greensfelder, Hemker & Gale, P.C., in St. Louis. "So on that basis, a hospital whose arrangements were otherwise compliant but not appropriately signed may have to give CMS back all the money they got from that physician's referrals." Without Stark changes, even mere technical errors in an APM's arrangements could be in violation.

ACOs protected — not APMs

Stark laws are part of a constellation of fraud-and-abuse laws such as the False Claims Act and the Civil Monetary Penalties Law (CMP), the latter of which prohibits provider gainsharing and has traditionally been considered an issue between hospitals and practices. In gainsharing, hospitals pay physicians to induce them to reduce or limit Medicare or Medicaid services, with the two parties sharing the savings (PBN 10/27/14).

As that is literally the model for Shared Savings and other Medicare ACO programs, in 2010 the Affordable Care Act created exceptions for them. But no such exceptions exist for APMs — not in MACRA or anywhere else. That's a potential problem.

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