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and **Christina M. Kuta, M.S.W., J.D., LL.M.,** Contributing Editors

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Experts analyze Stark Phase III in hypothetical situations

by **Susan Smith, J.D., M.A., Matthew Mann, J.D.,**
and **Valerie L. Witmer, J.D.,** Contributing Editors

Experts focused on hypothetical situations related to the stand in the shoes, joint ventures, and group practice and recruitment requirements as revised by the Stark Phase III final rule in “Stark in the Real World: Phase III as Applied,” Part II of a three-part audioconference series presented by the American Health Lawyers Association (AHLA) on October 25, 2007.

Stand in the shoes. In Stark Phase III, CMS narrowed its definition of indirect compensation arrangements by adopting the concept that a physician is deemed to stand in the shoes of his or her physician organization when the organization enters into a financial arrangement with a designated health service (DHS) entity. Therefore, the relationship between the physician organization and the DHS entity must be structured to fit into a direct compensation exception. This, according to Robert Homchick of Davis Wright Tremaine LLP, Seattle, Washington, is a change in focus from the relationship between the hospital and the group to the relationship between the group and the physician.

Homchick's hypothetical described various arrangements between a hospital and other entities, including a physician group, the physician group's back-up organization, a physician owned billing service, and a wholly owned affiliate that employs physicians. He explained that, under the stand in the shoes provision, a hospital's medical director agreement with a physician group must be in writing to satisfy a direct compensation exception. If an arrangement that was considered indirect prior to the revised rule is not in writing, it will not qualify for the grandfather provision for the current term of the arrangement. Homchick further noted that structured relationships with individual physicians avoid the application of the stand in the shoes provision.

If the physician group contracts with another physician group to provide back-up coverage, Homchick believes that the back-up group also would be considered to stand in the shoes of the group for which it was providing coverage. Therefore, to meet the in-office ancillary services exception, the contract between the two physician groups must be signed by the individual physician who is supervising ancillaries. If the original medical director agreement does not meet the direct exception, referrals from the back-up group will be tainted.

Homchick also described a situation in which a hospital establishes a wholly owned nonprofit entity to employ physicians. This entity assumes the contracts with the physician group and the billing service. The entity, Homchick said, is most likely a physician organization and its employed physicians still stand in the shoes

of the organization, even though the entity is not owned by physicians and the physicians are employees. Therefore, any financial relationships should fit within a direct exception. The stand in the shoes analysis of the financial relationships between the entity and the physician group and billing service remain the same.

Joint ventures. David Matyas of Epstein Becker & Green PC, Washington, D.C., analyzed situations in which a hospital and physicians enter into a joint venture LLC. In one hypothetical, the joint venture operated a general acute care hospital. Matyas cautioned that the fiscal year 2008 hospital inpatient prospective payment system final rule will include a definition of a physician owned hospital that will cross-reference Stark regulations. Matyas noted that under these rules, patients must be given written notice that a hospital is physician-owned and that patients can request a list of physician owners. Failure to abide by the requirements could result in termination or denial of the provider agreement. In addition, patients must be given written notice if a doctor is not present in the hospital 24 hours a day, 7 days a week. The notice must include a description of how the hospital will meet the medical needs of any patient who develops an emergency medical condition when no physician is present, according to Matyas.

Matyas explained that Stark would not apply to joint ventures involving ambulatory surgical centers (ASCs) because the definition of DHS does not include services that are reimbursed by Medicare as part of a composite rate. If, however, the ASC bills separately for any DHS, Stark may be implicated.

In the case of a management services company that manages a hospital's outpatient department and receives 15 percent of the hospital's oncology department revenues, Stark would be implicated to the extent that the physicians refer patients to the hospital, Matyas explained. He further explained that this joint venture should be analyzed as an indirect arrangement because the management

services company is not a direct biller of DHS. Matyas warned, however, that a percentage-based compensation arrangement might still be a problem, even under an indirect analysis. Nevertheless, Matyas said a stand in the shoes analysis, as well as an analysis of the personal services arrangement exception and other special rules on compensation, must be made.

Group practice and recruitment. Cynthia Reisz of Bass Berry & Sims PLC, Nashville, Tennessee, analyzed situations involving a physician group practice composed of internists and family practitioners operating through three offices, one of which has five physicians and x-ray and ultrasound services; another that has five physicians and a lab; and a third that has four physicians and EKG services. The group practice set up a compensation arrangement for physician employees comprised of a base salary equal to the greater of \$175,000 or 100 percent of the practice's net income (taking into account direct and indirect expenses) attributable to each physician's personally performed services and services provided incident to each physician's personally performed services.

According to Reisz, several facts must be determined, including: (1) whether the physicians are owners, employees (full- or part-time), or independent contractors; (2) who performs and supervises the ancillary services in each office; and (3) whether the physicians may be credited with net income from x-rays, ultrasounds, lab tests, or EKGs. Reisz noted that under Phase III, services that have their own separate and independently listed benefit category may not be billed as incident-to services; therefore, revenues derived therefrom may not be included in productivity bonuses.

In the hypothetical, the physician group contracted with a radiologist to interpret x-rays and ultrasounds. The physician group and a hospital then entered into a physician assistance agreement for the recruited radiologist. According to Reisz, the physician assistance agreement must be signed by the radiologist and the group as a guarantee to the extent

the group will benefit from money coming in for the radiologist's incremental expenses. CMS emphasized in Phase III that the recruitment exception requires the physician to join the medical staff. If the recruited radiologist is a fellow or resident at the hospital, he or she is not joining the medical staff as a full member, and the hospital cannot take part in the recruitment arrangement, Reisz noted. ■

CCH Chicago Bureau, Oct. 25, 2007.



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Requests for information about article submission and comments from readers are welcome and should be directed to Susan Smith at susan.smith@wolterskluwer.com, Tel. 847-267-2780, Fax 847-267-2514. Customer service inquiries should be directed to 800-449-9525.

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CIGNA agreement focuses on oversight, transparency in doctor ranking program

by Matthew Mann, J.D.,
Contributing Editor

An agreement between CIGNA Health-Care (CIGNA), one of the nation's largest health insurers, and the New York Attorney General (AG), Andrew M. Cuomo, will require the health insurer to fully disclose all aspects of its doctor ranking system to consumers and physicians, and retain an oversight monitor to ensure compliance with the agreement. The agreement, which was reached on October 29, 2007, is the first of its kind, although many more are expected to follow as an increasing number of insurers have implemented or are in the process of developing doctor ranking programs. The "core principles" of the agreement are accuracy and transparency of information, along with oversight of the process.

Background. Efforts within the health care industry to measure and report comparative quality and cost-efficiency data for doctors have increased in recent years. While public reporting of these measures is needed to help consumers make informed choices about their care and encourage providers to improve their performance, the process by which this data is collected and reported requires transparency, accuracy, and oversight – especially when there is the potential for a conflict of interest, such as when a program's sponsor also is an insurer.

CIGNA's physician ranking program, known as the "CIGNA Care Network" rates physicians practicing in 21 medical specialties based on their performance on certain quality and cost-efficiency measures. The AG's office became aware of CIGNA's program as part of its industry-wide investigation into doctor ranking programs.

Accuracy and transparency. Under the agreement, CIGNA will be required to use established national

standards to measure quality, including measures endorsed by the National Quality Forum, if available, or other entities whose work in the area of physician quality performance is generally accepted in the health care industry. CIGNA also will utilize several measures to foster more accurate physician comparisons, including risk adjustment and valid sampling.

Information for consumers. In all publicly reported information for consumers, measures of cost-efficiency and quality will be calculated and reported separately. In the event that a ranking is formulated by combining a quality score and a cost-efficiency score, the proportion of each measure will be clearly disclosed. In addition, CIGNA must disclose the following information to consumers within 30 days of the agreement:

- where its physician performance ratings can be found;
- a statement to the effect that the ratings are only a guide with a risk of error and should not be the sole basis upon which to choose a doctor;
- the basis upon which physician performance is measured, including any limitations of the data used to compute ratings;
- how physicians are selected for inclusion or exclusion from the program; and

- how the consumer may register a complaint with CIGNA and the oversight monitor.

CIGNA also will contribute up to \$100,000 to an independent organization to research ways to improve the presentation of the data to help consumers understand the system.

Information for physicians. Following review of its program by the oversight monitor, CIGNA must disclose to physicians in detail the methodologies and data used to determine quality and cost-efficiency ratings. CIGNA also must inform physicians of their ability to correct errors and seek review of data, ratings, and inclusion or exclusion from the program.

Oversight. An oversight monitor, to be known as the "Ratings Examiner" (Rx), will be responsible for assuring compliance with the terms of the agreement. The Rx will be a nationally recognized standards setting organization, selected and paid for by CIGNA, but approved by the AG. The Rx will report and make recommendations to the AG every six months on the details of the methodologies used and the extent to which they reflect national standards and compliance with the agreement. ■

New York Attorney General Press Release, Oct. 29, 2007; Agreement In the Matter of Connecticut General Life Insurance Co. and CIGNA HealthCare of New York, Inc., Oct. 29, 2007.

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The Stark law changes are here today – but may be completely different tomorrow

by **Ericka L. Adler, J.D., LL.M.** and **Christina M. Kuta, M.S.W., J.D., LL.M.**

The Stark law is currently in a state of transition, with changes reflected in Stark II, Phase III (“Phase III”) effective December 5, 2007,¹ as well as two significant changes related to independent diagnostic testing facilities and professional and technical component anti-markup provisions.² Additionally, regulators recently proposed a myriad of regulations, which may be adopted at any time after January 1, 2008.³ This article provides a brief summary of all of the recently adopted Phase III rules and the proposed regulations.

Stark II, Phase III regulations

The Phase III rules, effective December 5, 2007, changed several provisions of the regulations governing physician referrals. Major changes included addition of the stand in the shoes provision, modification of the in-office ancillary services and physician recruitment exceptions, as well as changes to other provisions that impact physicians' ability to maintain an ownership or investment interest in related entities.

In-office ancillary services exception

Currently, Stark allows multiple physician groups to co-locate in the same building and share Designated Health Services (DHS) facilities. Commentary to the Phase III rules suggests that, to continue such arrangements, physicians sharing DHS facilities in the same building must “control” the facility and staffing at the time the DHS is furnished to the patient, and that sufficient control will likely necessitate a block lease arrangement or other safeguards. Phase III does, however, stop short of actually requiring a block lease, but it is clear that a lease based on “per-click” or “per-unit” of time (where a physician pays a leasing fee only for each time he or she uses the equipment) no longer will satisfy the control requirement of the in-office ancillary services exception.

CMS further cautions that off-site, same building, shared facility arrangements must fully comply with the in-office ancillary services exception in operation and not merely in formation. To this end, each group practice part of a shared facility arrangement must meet the billing, location, and supervision requirements of the in-office ancillary services exception. (See 72 FR at 51032-35).

Stand in the shoes

Phase III provides that, when reviewing otherwise indirect compensation arrangements, a physician “stands in the shoes”

of his “physician organization.” Therefore, a physician is deemed to have a direct compensation arrangement with an entity furnishing DHS if the only intervening entity between the physician and the entity furnishing DHS is the physician organization. Physician organization is defined as: (1) a professional corporation with a sole physician owner; (2) a physician practice; or (3) a group practice under Phase III. For example, to the extent a group practice (physician organization) has a professional financial relationship with a hospital (DHS entity), an independent contractor physician contracting with a group practice is now deemed to “stand in the shoes” of the group practice, resulting in a direct financial relationship between the hospital and the independent contractor physician. Any referral that the independent contractor physician makes to the hospital will need to fit within a Stark exception. (See 72 FR at 51061-63; 42 C.F.R. §§411.354(a), (c)).

Physician recruitment exception

In Phase III, CMS has relaxed recruitment regulations and will allow covenants not to compete that do not “unreasonably restrict the recruited physician’s ability to practice medicine in the geographic area served by the hospital.” There is no on-point guidance as to what constitutes an “unreasonable restriction;” however, a covenant that does not comply with state law would likely be deemed “unreasonable.” CMS further stated that the following restrictions do not, *per se*, have a significant effect on a physician’s ability to practice medicine in the hospital’s geographic area: prohibiting moonlighting; prohibitions on soliciting patients or employees; requiring recruited physicians to repay losses of their practice absorbed by the physician practice; and liquidated damages if a physician leaves the practice and remains in the community (as long as the liquidated damages are not significant or unreasonable).

Additional changes to the recruitment rules include:

- expanding the definition of which providers are eligible for the recruitment exception;

- allowing income guarantees for recruited physicians who replace retired, relocated or deceased physicians;
- expanding the definition of the geographic area served by the hospital for rural hospitals; and
- allowing retention payments by hospitals, rural health clinics, or federally qualified health centers to physicians who do not yet have a written offer of recruitment or employment. (See 72 FR at 51047-54; 42 C.F.R. §411.357(e)).

Fair market value compensation

CMS clarified in Phase III that arrangements for the rental of office space must comply with the Stark office space exception and cannot rely solely on the fair market value exception. (See 72 FR at 51059-60; 42 C.F.R. §411.357(l)).

Profit shares and bonus compensation for “incident-to” services

CMS clarified the rules on payment of profits based on services provided “incident-to” physician services. Profit income cannot be divided in any manner that takes into account the volume or value of referrals for incident-to services; however, physicians can be paid a productivity bonus based directly on incident-to services (such as services provided by a physical therapist), as long as the bonus is not directly related to the volume or value of any other type of DHS referral (such as diagnostic tests). (See 72 FR at 51022-24; 42 C.F.R. §411.352(i)).

Holdovers for personal services arrangements

Phase III now allows for a hold-over period whereby physicians working under a personal services arrangement may continue to work six months past the expiration date of the agreement; provided, however, that the arrangement otherwise meets the requirements of the personal services exception. (See 72 FR at 51045-47; 42 C.F.R. §411.357(d)).

Fair market value safe harbor eliminated

Under Phase II, CMS detailed a “safe harbor” provision related to hourly payments to physicians for personal services. CMS eliminated this safe harbor in Phase III, finding it impractical and infeasible; however, CMS will continue to scrutinize the fair market value of all personal services arrangements. CMS further acknowledged that parties may calculate fair market value using commercially reasonable methods appropriate to the circumstances. (See 72 FR at 51015).

Compliance training

The Phase III compliance training exception covers compliance training programs that provide continuing medical education credit; however, compliance training must be the primary purpose of the program. (See 72 FR at 51061; 42 C.F.R. §411.357(o)).

Excess nonmonetary compensation

Phase III allows a physician to “cure” excess nonmonetary compensation that was provided inadvertently under certain circumstances. Additionally, an entity may provide one “staff appreciation” function per year without regard to the nonmonetary compensation limit. (See 72 FR at 51058-59; 42 C.F.R. §411.357(k)).

Academic medical centers

Phase III has revised the academic medical center exception. Under Phase III, the total compensation from each academic medical center component to a faculty physician must be: (1) set in advance; and (2) not determined in any way that takes into account the value or volume of referrals or business generated. (See 72 FR at 51036-38; 42 C.F.R. §411.355(e)).

Intra-family rural referrals

The Stark law currently allows referrals from a physician to his immediate family, or a DHS entity in which an immediate family member has an interest, provided, in part, that there are no other providers available within 25 miles of the patient’s home. Phase III further clarified that such referrals also may be Stark compliant if, at the time the referral is made, there are no other providers within 45 minutes transportation time from the patient’s residence. (See 72 FR at 51039-41; 42 C.F.R. §411.355(j)).

Professional courtesy

Phase III no longer requires that a provider or entity notify an insurer when reducing an obligation, wholly or partially, based on professional courtesy. This provision only applies to hospitals and providers with “formal medical staffs” (such as group practices), and not to DHS suppliers. (See 72 FR at 51064-65; 42 C.F.R. §411.357(s)).

Adopted Stark II regulations

Effective January 1, 2008, CMS has made significant changes related to independent diagnostic testing facilities, as well as the reassignment and physician self-referral rules relating to diagnostic tests.

Independent Diagnostic Testing Facilities

CMS has adopted a provision revising §410.33(g)(15) such that, with the exception of hospital-based and mobile independent diagnostic testing facilities (IDTFs), a fixed based IDTF may not: (1) share a practice location with another Medicare-enrolled individual or organization; (2) lease or sublease its operations or practice location to another Medicare-enrolled individual or organization; or (3) share diagnostic testing equipment used in the initial diagnostic test with another Medicare-enrolled individual or organization. This proposal virtually eliminates

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the ability of fixed based IDTFs to enter into any type of space or equipment lease with a physician practice or other individual or entity, regardless of whether the lease is based on per-click or block of time. Although this regulation goes into effect January 1, 2008, CMS has adopted a one-year transition period for IDTFs currently sharing a practice location with another Medicare individual or organization. This transition period, however, does not extend to IDTFs currently maintaining leasing or subleasing agreements or sharing diagnostic testing equipment. Any leasing of space or equipment must be amended, as applicable, beginning January 1, 2008.

Anti-markup provision for diagnostic tests

CMS has adopted an anti-markup provision on the technical component (TC) and professional component (PC) of diagnostic tests. The originally proposed anti-markup regulation would have taken into account the employment status of the physician provider: independent contractor or part-time employee versus full-time employee. (See 72 FR at 38179-80). The adopted final provision makes no distinction based on employment status, considering only whether the PC or TC was purchased and where it was performed. The new regulations specifically prohibit any mark up of the TC or PC if: (1) the TC or PC is purchased (*i.e.*, a purchased diagnostic test); or (2) the TC or PC is performed at a site other than the office of the billing physician or billing supplier.

For example, a group practice physician orders a diagnostic test, which is performed by a part-time technician employed by the practice (the TC). An independent contractor radiologist interprets the test in the practice's office (the PC). The anti-markup provision will not apply for the group to bill either the PC or the TC. If the radiologist performed the PC in her own private office, anti-markup would apply to the PC because it was not performed at the office of the billing physician (group practice). If the radiologist performs the PC in her own office, but does not reassign the right to bill the PC to the physician ordering the test, but instead bills for the PC herself, anti-markup will not apply because the PC was performed at the office of the billing physician.

Proposed Stark II regulations

The following represent the proposed changes to the Phase III regulations. At this point, it is impossible to discern when, or if, any or all of these proposed changes will be adopted. Given the volume of public comment, the number of proposals, and the significance of the provisions, CMS has decided to defer adopting any of these proposals until sometime after January 1, 2008. Many of these changes, however, have been discussed in prior Stark commentary, and accordingly, it is quite likely that at least some form of these proposed regulations will become a reality in the near future.

Burden of proof

CMS has proposed to add 42 C.F.R. §411.355(g), providing that in an appeal of a denial of payment for DHS made on the basis that the service was furnished pursuant to a prohibited refer-

ral, the burden would be on the entity submitting the claim for payment to show that the service was not based on a prohibited referral. (See 72 FR at 38180). For example, if a claim made by a physician in a group practice is denied based on the fact that Medicare believes it was furnished through a prohibited referral, that physician would bear the burden to prove the referral was not prohibited under Stark. To do so, the physician could show he or she is part of a qualifying group practice and the referral was made pursuant to the in-office ancillary services exception.

In-office ancillary services exception

There is no specific proposal for amending §411.355(b). CMS received earlier comments stating this section did not address potentially abusive arrangements within the physician's office, such as in-office laboratories and the migration of sophisticated and expensive imaging equipment to physician offices. Comment was requested on: whether certain services should be excluded from the exception; changes to the location requirements; whether non-specialist physicians should be able to use the exception to refer for specialized services using equipment owned by non-specialists; and any other suggestions to curtail abuse. (See 72 FR at 38181-82).

Obstetrical malpractice insurance subsidies

CMS has proposed to revise §411.357(r) to list conditions that would be appropriate to safeguard against program or patient abuse when remuneration is provided by a hospital to a physician in the form of an obstetrical malpractice insurance subsidy. CMS also has proposed a provision that would mandate compliance with federal and state law governing billing or claims submission, as well as the anti-kickback statute. (See 72 FR at 38182).

Unit-of-service (per-click) payments

CMS believes Congress intended for time-based or unit-of-service based payments to be protected, so long as payment per unit is fair market value at inception and does not change in any manner that takes into account DHS referrals. CMS has proposed to revise §§411.357(a) and (b) to provide that space and equipment leases may not include unit-of-service-based payments to a physician lessor for services rendered by an entity lessee to patients who are referred by a physician lessor to the entity. CMS believes that such arrangements are inherently susceptible to abuse.

CMS has requested comment on whether, pursuant to its authority in Social Security Act §1877(e)(1), it should prohibit time-based or unit-of-service-based payments to an entity lessor by a physician lessee, to the extent such payments reflect services rendered to patients sent to the physician lessee by the entity lessor. (See 72 FR at 38182-83).

Period of disallowance for noncompliant financial relationships

CMS has not proposed any specific revisions related to the period of disallowance for noncompliant financial relationships. CMS has

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requested comment on how to set forth a period of disallowance for arrangements that implicate, but fail to satisfy, the requirements of one or more of the various exceptions. (See 72 FR at 38183).

Ownership or investment interest in retirement plans

CMS has proposed to revise §411.354(b)(3) to provide that the ownership and investment interests exception would relate only to investment interests in employer-sponsored retirement plans offered to the physician or immediate family member as a result of the physician's or immediate family member's employment with an entity. (See 72 FR at 38183-84).

This proposal is born from CMS' concern that some physicians are circumventing Stark via retirement investments. For example, if a physician group participates in a retirement plan that invests in an imaging facility to which the physicians refer, the physicians currently can make such referrals without violating Stark because they claim investment in the plan and not in the actual imaging facility.

Set in advance and percentage based compensation arrangements

CMS has proposed to clarify §411.354(d) to provide that percentage compensation arrangements may be used only when paying for personally performed physician services and must be based on revenues directly resulting from the physician services rather than some other factor, such as a percentage of the savings by a hospital department (which is not directly or indirectly related to the physician services provided). (See 72 FR at 38184).

Stand in the shoes

CMS has proposed to amend §411.354(c) to provide that when a DHS entity owns or controls an entity to which a physician refers Medicare patients for DHS, the DHS entity would stand in the shoes of the entity that it owns or controls and would be deemed to have the same compensation arrangement with the same parties and on the same terms as does the entity it owns or controls.

CMS has requested comment on how to employ a stand in the shoes approach for various financial relationships. CMS is concerned that individuals may circumvent the prohibition on self-referrals by inserting an entity or contract in the chain linking a DHS entity to a referring physician, for example, when a group practice owns a leasing company that leases imaging equipment to a hospital. (See 72 FR at 38184).

Alternative criteria for certain exceptions

CMS has proposed to amend certain exceptions in §§411.355-411.357 to address inadvertent violations, such as when an agreement fails to satisfy the procedural "form" requirement of an exception of the statute or regulations. For example, the inadvertent failure of a physician lessee to sign a lease for office space, while a technical violation of the space lease exception, would meet this proposed exception as a failure of procedural form. Failure to set the term of a lease in excess of one year, however,

would not qualify for the exception because it is considered more than a mere procedural defect. (See 72 FR at 38184-86).

Services provided under arrangements

CMS noted that as of January 1, 2008, Medicare may pay more for hospital outpatient surgical procedures than for the same procedures billed by ambulatory surgery centers (ASCs) under the revised ASC payment system, as mandated by §626(b) of the Medicare Modernization Act of 2003. CMS has proposed to revise §411.351 so that the definition of a "DHS entity" would include the person or entity that performs the DHS, as well as the person or entity that submits claims or causes claims to be submitted to Medicare for DHS (the DHS service provider). This proposal appears to address CMS' concern that many physicians are establishing joint ventures with hospitals whereby the physicians provide imaging services (services that were formerly provided by the hospitals directly) for a fee, and the hospital bills for the services, receiving a higher rate of reimbursement from Medicare than that offered to the physician. (See 72 FR at 38186).

Further, CMS has requested comment on whether it should adopt a Medicare Payment Advisory Commission (MedPAC) recommendation to extend the definition of physician ownership to include an interest in an entity that derives a substantial portion of revenue from a provider for DHS. CMS is especially interested in receiving comment on what should constitute a "substantial" portion of revenue derived from providing DHS. (See 72 FR at 38187).

Future implications

Both the Phase III rules and the proposed regulations reflect an effort by CMS to further define and in many instances, restrict, the ability of physicians to maintain an ownership or investment interest in related corporate entities. During this time of change, it is imperative for health care attorneys to be familiar with the current and future changes stemming from increased regulatory scrutiny of health care transactions. While it remains to be seen exactly what will be at the end of the Stark highway, it is clear that all signs along the way lead toward significant review, and potential restructure, of many health care relationships. ■

Ms. Adler is a partner with the firm of Kamensky Rubinstein Hochman & Delott, LLP and focuses her practice in the area of regulatory and transactional health care. She is a frequent author on the topic of health care regulations, and is a Director of the Illinois Association of Healthcare Attorneys

Ms. Kuta is an associate with the health care department of Kamensky Rubinstein Hochman & Delott, LLP, and concentrates her practice in the area of regulatory and transactional health care.

¹ Final rule, 72 FR 51012-51099, Sept. 5, 2007. While the Phase III changes are not currently in place, there is essentially no "grandfather" provision, therefore any transaction contemplated or in existence today will need to be structured to meet the changes of tomorrow.

² CMS Release, CMS-1385-FC, Nov. 2, 2007, at <http://www.cms.hhs.gov/physicianfeesched/downloads/CMS-1385-FC.pdf>.

³ Proposed rule, 72 FR 38122-38395, July 12, 2007.

New hospital exemption requirements proposed

by Brant Goldwyn,
Contributing Editor

A Republican staff draft of potential reforms involving nonprofit hospitals sparked a Senate Finance Committee roundtable discussion on the need to impose additional requirements on hospitals seeking federal tax-exempt status.

Ranking committee member Sen. Charles Grassley (R-Iowa) urged the IRS and Treasury to take action before Congress considers legislation. "I've urged the Administration to look at nonprofit hospitals and what duties of charity care and community benefit they should provide."

The staff draft recommended intermediate sanctions for hospitals that fail to meet annual charity care or community benefit requirements. The excise taxes would be at least twice the hospital's shortfall. The IRS also could revoke the hospital's exempt status, in which case HHS would be notified and could take the revocation into account when considering whether the hospital should continue as a Medicare provider.

The draft also said that the community benefit standard is "extraordinarily vague and does not correlate with the federal tax benefits received by the hospital." Professor John Colombo of the University of Illinois agreed, saying that the standard allows hospitals to claim that everything provides a community benefit. Keith Hearle of Verite Healthcare Consulting said that hospitals provide community benefit that includes more than charity care. He would include Medicaid losses in the definition of community benefit. Ralph Lawson of the Healthcare Financial Management Association opined that charity care should be evaluated based on costs, not revenues or Medicare and Medicaid reimbursement.

At Grassley's request, the Government Accountability Office is preparing a report on the IRS, state governments, and nonprofits' definition of community benefit, as well as nonprofits' definition of charity care. The report is due in the spring of 2008. ■

CCH Washington Bureau, Oct. 31, 2007.

In the News

CMS launches EHR pilot program

A five-year demonstration project that will encourage small to medium-sized physician practices to adopt electronic health records (EHRs) has been announced by HHS Secretary Michael Leavitt. Over a five-year period, the project will provide financial incentives to physician groups using certified EHRs to meet certain clinical quality measures. A bonus will be provided each year based on a physician group's score on a standardized survey that assesses the specific EHR functions a group employs to support the delivery of care. "Broad adoption of [EHRs] has the potential not only to improve the quality of care provided, but also to transform the way medicine is practiced and delivered," Leavitt said. "We are looking for 1,200 physician practice pioneers who will help us move health care toward a system that delivers better quality at lower cost for more Americans," he added.

HHS Press Release, Oct. 30, 2007.

Reference lab pays \$1.5 million to resolve FCA claims

Dianon Systems, Inc. has agreed to pay the United States \$1.5 million to resolve claims under the Federal False Claims Act (FCA) that the company mischarged Medicare and TRICARE for certain tests it performed, the Justice Department announced. Dianon specializes in conducting tests to detect and stage various types of cancer, including flow cytometry tests, which can be used to measure the amount of DNA in cells. Doctors obtain tissue or liquid specimens from patients and refer the specimens to Dianon to determine whether they contain cancer cells, and, if so, the stage of the disease. A pathologist formerly employed by Dianon filed suit on behalf of the United States under the FCA's *qui tam* provision, alleging that the company billed for medically unnecessary tests by performing 26 flow cytometry tests on every sample sent to the company for diagnosis, regardless of whether all 26 tests were medically necessary for a particular patient. The pathologist will receive \$300,000 as his share of the settlement proceeds.

DOJ Press Release, Oct. 30, 2007.

First site for clinical lab bidding demonstration selected

CMS has selected the San Diego-Carlsbad-San Marcos, California metropolitan area as the first of two locations for a competitive bidding demonstration for clinical laboratory services provided to fee-for-service Medicare beneficiaries. The demonstration, which was mandated by the Medicare Modernization Act of 2003 (MMA) (PubLNo 108-173) is designed to determine whether competitive bidding can be used to provide laboratory services under Medicare Part B at fees below current Medicare payment rates, while maintaining quality and access to care, according to CMS Acting Administrator Kerry Weems. The demonstration will include laboratories providing services to beneficiaries enrolled in traditional fee-for-service Medicare and living in the demonstration area. Winners will be selected based on bid price, as well as quality, capacity, geographic coverage, and other criteria. Conditions for participation in the demonstration will include the quality standards required by the Clinical Laboratory Improvement Amendments, as well as performance measures such as turnaround times, error rates, and rates of lost specimens.

CMS Press Release, Oct. 17, 2007.