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in the news

Health Care

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Important Changes for Physicians from the 2016 Medicare Physician Fee Schedule: Part I (Stark Changes)

In this Issue:

On November 16, 2015 the Centers for Medicare and Medicaid Services (CMS) published the final Medicare Physician Fee Schedule (Final MPFS).[1] The Final MPFS addresses changes to the physician fee schedule and related policies, reflecting the continued shift away from fee-for-service to a value-based reimbursement system. Except for the changes to the Stark definition of "ownership or investment interest," which goes into effect January 1, 2017, the provisions in the Final MPFS are effective January 1, 2016. Comments will be accepted on the Final MPFS through December 29, 2015. Summarized below are select highlights from the Stark Related Physician Fee Schedule Changes in the Final MPFS.

In the Final MPFS, in addition to updating the "designated health services" list,[2] CMS included important Stark Law changes including: (i) expansion of the recruitment exception; (ii) technical changes including clarification of the "in writing" and signature requirements and extension of the holdover provisions for several exceptions; (iii) clarification of certain definitions and exceptions; and (iv) new timesharing arrangement exception.

Recruitment of Non-Physician Practitioners. Tracking closely the existing exception for physician recruitment, the Final MPFS provides a limited exception for hospitals, federally qualified health centers and rural health clinics that wish to provide remuneration in the form of capped compensation and limited benefits to a physician organization with the employment of a non-physician practitioner (PAs, NPs, CNSs, and CNMs) who provides only primary care services.[3]

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[1] 80 Fed. Reg. 70886 (November 16, 2015).

[2] The updated, comprehensive Code List effective January 1, 2016, is available on the CMS website at *http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/List_of_Codes.html*.

[3] 42 C.F.R. 411.357(x)

Technical Changes - Writing & Signature Requirements for Compensation Exceptions; Holdover Provision. Recognizing that the "in writing" requirement of several of Stark exceptions (e.g. space and equipment leases, personal services arrangements, physician recruitment, etc.) – have created issues leading to self-disclosure, HHS clarifies that these exceptions do not require a single formal contract but rather, depending on the facts and circumstances, a collection of documents, including contemporaneous documents evidencing the course of conduct between the parties, may satisfy the "in writing" requirement for these exceptions. Similarly, recognizing the technical compliance problem that excepted arrangements have a "term of at least one year," CMS clarified that this term (for space and equipment leases and personal services arrangements) do not have to be in writing as long as the arrangement clearly establishes a business relationship that will last for a year and/or, as a matter of fact, lasts for at least a year. The Final MPFS also allows parties up to 90 days to obtain the required signatures, regardless of whether or not the failure to obtain the signature(s) was inadvertent. Additionally, CMS extended the "holdover" time period for arrangements of at least one year from a six month period to an indefinite period.

Clarification of Definition of Remuneration. The Final MPFS clarifies that the definition of "remuneration,"[4] does not include the provision of an item, device, or supply that is used for one or more of the six purposes listed in the statute, and no other purpose. However, remuneration is conferred by a hospital to a physician when both facility and professional services are provided to patients in a hospital-based department. Finally, CMS clarifies that arrangements between physicians and DHS entities where the physician provides services to a patient and bills the payor for his or her services, and the DHS entity provides its resources and services to the patient and bills the payor for the resources and services, does not create remuneration between the parties; however, if a physician or a DHS entity bills a payor globally for both the physician's services and the hospital's resources and services, a benefit is conferred on the party receiving payment, which implicates the Stark Law.

Clarification of Definition of Stand in Shoes. The Final MPFS clarifies several important points for the "stand in the shoes" provisions specific to compensation arrangements.[5] First, CMS does not consider employees and independent contractors parties to a physician organization's arrangements unless they voluntarily stand in the shoes of the physician organization. In such instance, the physician satisfies the signature requirement of an applicable exception when the authorized signatory of the physician organization has signed the writing evidencing the arrangement. However, for purposes *other than* satisfying the signature requirements of the exceptions, CMS remains concerned about the referrals of *all* physicians who are part of a physician organization that has a compensation arrangement with a DHS entity when we analyze whether the compensation between the DHS entity and the physician organization takes into account the volume or value of referrals or other business generated between the parties. Therefore, employees and independent contractors are like are considered in this analysis. Finally, CMS clarifies its intent that the "stand in the shoes" provisions are specific to compensation arrangements and are separate and distinct from its definition of a *locum tenens* physician, and revised the definition of *locum tenens* physician at by removing the phrase "stands in the shoes."

Revision to Exception for Ownership in Certain Publicly Traded Securities. Because the NASD no longer exist and it is no longer possible to purchase a publicly traded security traded under the automated interdealer quotation system it

[4] 42 C.F.R. § 411.351
[5] 42 C.F.R.§ 411.354(c).
[6] 42 C.F.R. § 411.351.

formerly operated, CMS revised this exception[7] to include securities listed for trading on an electronic stock market or OTC quotation system in which quotations are published on a daily basis and trades are standardized and publicly transparent, such as the NYSE or the American Stock Exchange.

Clarification to Exception for Physician-Owned Hospitals. The Final MPFS provides physician-owned hospitals more certainty regarding the forms of communication that require a disclosure statement and the types of language that would constitute a sufficient statement of physician ownership or investment for purposes of this exception. Specifically, CMS clarifies that social media Web sites; a hospital's individual page on a Web site, posting a video, or posting messages; and electronic patient payment portals, electronic patient care portals, or electronic health information exchanges, do not constitute "public Web sites." CMS further clarifies that any language that would put a reasonable person on notice that the hospital may be physician-owned is deemed a sufficient statement of physician ownership or investment, including statements that "this hospital is owned or invested in by physicians" or "this hospital is partially owned or invested in by physicians," the hospital is "founded by physicians," "managed by physicians," "operated by physicians," or "part of a health network that includes physician-owned hospitals," or even the hospital's name itself.[8] Such language should be displayed in a clear and readable manner and located in a conspicuous place on the Web site and on a page that is commonly visited by current or potential patients, such as the home page or "about us" section. In the event that a physician-owned hospital discovers that it failed to satisfy the public Web site or public advertising disclosure requirements, CMS specifies that the Self-Referral Disclosure Protocol is the appropriate means for reporting such overpayments.[9]

The Final MPFS also amends this exception to provide that it will include the ownership or investment interests held by all types of owners or investors, regardless of their status as referring or non-referring physicians are included in the *bona fide* investment level.

Exception for Timeshare Arrangements. The Final MPFS finalizes the exception for timeshare arrangements[10] to require that a timeshare arrangement for premises, equipment, personnel, items, supplies, and/or services must be between a physician (or the physician organization) and: (i) a hospital or (ii) a physician organization of which the physician is not an owner, employee, or contractor. Further, equipment covered by the timeshare arrangement may be in the same building[11] as the office suite where E/M services are furnished. Third, all locations under the timeshare arrangement, including the premises where E/M services are furnished and the premises where DHS are furnished, must be used on identical schedules. CMS clarifies that the exception protects only those arrangements that grant a right or permission to use the premises, equipment, personnel, items, supplies, or services of another person or entity without establishing a possessory leasehold interest (akin to a lease) in the medical office space.

Finally, because the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires Secretary of HHS to issue two reports – the APM Report and the Gainsharing Report, CMS solicited comments regarding the impact of the Stark Law on health care delivery and payment reform, including the "volume or value" and "other business generated" standards to assist in determining the need for additional rulemaking or guidance. CMS is in the process of incorporating some of those comments into the required Reports.

[7] 42 C.F.R. § 411.356(a)(1).
[8] 42 C.F.R. § 411.362(b)(3)(ii)(C).
[9] *Special Instructions for Submissions to the CMS Voluntary Self-Referral Disclosure Protocol for Physician-Owned Hospitals and Rural Providers that Failed to Disclose Physician Ownership on any Public Web site and in any Public Advertisement*, available on our Web site at http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Self_Referral_Disclosure_Protocol.html.
[10] 42 C.F.R. § 411.357(y).
[11] 42 C.F.R. § 411.351.

For More Information

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