

## Proposed Stark Law Changes May Impact Physician Compensation Models

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On October 9, 2019, the Centers for Medicare and Medicaid Services ("CMS") proposed sweeping changes to the federal Physician Self-Referral Law, commonly referred to as the Stark Law. While many of the changes reflect CMS' intent to allow greater flexibility to address certain value-based compensation arrangements, a somewhat overlooked proposal could have a material effect on how physician group practices allocate profits from Stark Law designated health services ("DHS"). Currently, many physician group practices, especially large or multi-specialty practices, allocate DHS profits to its physicians based on DHS categories. The result is that profits from one DHS category (e.g., imaging services) may be allocated to certain physicians in the group practice while profits from a second DHS category (e.g., physical therapy) may be allocated to a different (or possibly overlapping) subset of physicians in the group practice. Under the proposed rule, CMS would eliminate this approach and require that profits from all DHS be aggregated and distributed to either all physicians in the group practice or a component of at least five physicians in the group practice.

By way of background, the Stark Law prohibits a physician owner or employee of a medical practice from ordering DHS from the medical practice paid by Medicare or Medicaid, unless a Stark Law exception applies. DHS includes, among other items, clinical laboratory services, physical, occupational and speech therapy, certain imaging services, radiation therapy, durable medical equipment, and outpatient prescription drugs. Under the Stark Law, a medical practice with at least two physicians must qualify as a "group practice" to take advantage of the Stark Law in-office ancillary services exception, which is often used to allow a physician owner or employee to order DHS from his or her medical practice. As part of the group practice requirements, DHS profits must be distributed to all physicians in the group, or to a pod of five or more physicians, in a manner that does not directly take into account the volume or value of a physician's referrals for DHS.

It is not uncommon for a physician group practice to share DHS profits from one type or category of DHS among a subset of physicians in the group practice and share the profits from another type or category of DHS with a different (possibly overlapping) subset of physicians in the group practice. Consider, for example, a group practice comprised of twenty physicians. The group practice may allocate DHS profits from imaging services to all physicians, since all physicians order imaging services, but allocate DHS profits from physical therapy to only those ten physicians who order physical therapy for their patients. Further, the group practice may allocate DHS profits from imaging services equally among all physicians and may allocate DHS profits from physical therapy based on each participating physician's non-DHS revenue as a percentage of all non-DHS revenue generated by the participating physicians. Either profit allocation method is permissible under the Stark Law. This manner of

distributing DHS profits is especially prevalent in multi-specialty group practices where different physician specialties use different DHS.

In its discussion accompanying the proposed rule change, CMS states that it did not intend for DHS profits to be distributed on a service-by-service basis. According to CMS, all DHS profits must be aggregated and paid to all physicians in the group practice, or a component of at least five physicians in the practice, in a manner that does not directly take into account (that is, in any manner that is directly related to) the volume or value of a physician's DHS referrals. To illustrate its point, CMS provides the following example: suppose a physician practice provides both clinical laboratory services and diagnostic imaging services to its patients. According to CMS, "[i]f the practice wishes to qualify as a group practice, it may not distribute the profits from clinical laboratory services to one subset of its physicians or using a particular methodology and distribute the profits from diagnostic imaging to a different subset of its physicians (or the same subset of its physicians but using a different methodology)."

There are four takeaways from CMS' proposal. First, since CMS states that its proposed changes are merely a clarification of existing policy, it is likely that the proposal will be adopted as a final rule. Second, in its discussion accompanying the proposed changes there is no indication by CMS that group practices that have previously allocated DHS profits on a service-by-service basis have done so in violation of the Stark Law. CMS appears to recognize that its prior regulatory guidance on this issue has led to confusion by industry participants. Third, CMS proposes that profits from *all* DHS received by a physician group practice must be aggregated and distributed in a Stark Law compliant manner to all physicians in the group practice or a component of at least five physicians in the practice. Finally, it appears that CMS not only requires that a physician group practice aggregate and distribute profits from all DHS, but seems to suggest that the practice must use a single methodology to distribute such profits. Using my example above, a group practice with twenty physicians would be required to combine DHS profits from both imaging and physical therapy services. Either all twenty physicians would need to participate in the DHS profit pool or a component of five or more physicians. CMS appears to suggest that all DHS profits would need to be allocated using a single methodology, and, for example, it would not be permissible to allocate the imaging service profits equally among the participating physicians and allocate the physical therapy profits to the same participating physicians based on a different Stark Law compliant methodology.

In its proposed rule, CMS has confirmed that a physician group practice may continue to pay ordering physicians a productivity bonus based on DHS revenue from services personally performed or from services provided "incident to" the physicians personally performed services. Further, since the Stark Law only covers Medicare and Medicaid DHS revenue, a group practice can directly compensate its physicians for ordered DHS paid for by other payers, absent any applicable state law referral restrictions.

Public comments to the proposed Stark Law changes are due by December 31, 2019 and it is anticipated that CMS will finalize the changes mid to late 2020.

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