PUBLICATION

Stark Regulations: Proposed Physician Recruitment Provisions [Ober|Kaler]

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Assistance to Employ a Non-Physician Practitioner (NPP)

Currently under the Stark law, the physician recruitment exception (42 C.F.R. § 411.357(e)) permits hospitals, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to provide remuneration to physicians and/or group practices to assist with recruitment and/or retention of physicians into the geographic area served by the hospital, FQHC, or RHC, in order to be a member of the medical staff. The current exception as drafted is applicable to physicians only. In fact, in Stark II, Phase III, CMS expressly declined to expand 42 C.F.R. § 411.357(e) to cover the recruitment of non-physician practitioners (NPPs) into a hospital's geographic service area. In that rulemaking, CMS distinguished between payments made directly to the NPP, which would not implicate the Stark law and payments made to a physician practice for the recruitment of the NPP, which would implicate the statute and for which no exception would apply.

CMS has since recognized that there have been significant changes in health care delivery and payment systems, including primary care workforce shortages. In light of this shortage, CMS has proposed a new exception at 42 C.F.R. § 411.357(x) to permit recruitment assistance and retention payments from hospitals, FQHCs, and RHCs to an individual physician to assist the physician in employing NPPs in the geographical area served by the hospital, FQHC, or RHC providing the remuneration. The proposed exception would also protect deemed "direct" compensation arrangements between a hospital, FQHC, or RHC and the physicians standing in the shoes of the physician organization (including a physician's group practice) to which the hospital, FQHC, or RHC provided the remuneration.

The provisions of the proposed exception, which must be satisfied in order for the recruitment activity to be afforded protection, are as follows:

- The NPP must be a bona fide employee of the physician (or physician's group practice when the physician is deemed to stand in the shoes of his or her group practice).
- The purpose of the NPP's employment is to provide *primary care services* (i.e., general family practice, general internal medicine, pediatrics, geriatrics, and OB/GYN services).
- NPPs are defined to include: physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives. Certified registered nurse anesthetists are not included.
- CMS proposed two alternatives for establishing the minimum amount of primary care services the NPP must furnish to patients of the physician's practice.
  - NPP must furnish at least 90 percent of primary care services; or
  - NPP must furnish substantially all primary care services.
- CMS indicated that it does not intend the amount or duration of the support to be unlimited and has proposed caps:
  - **Total Remuneration:** CMS proposes to cap the remuneration at the lower of 50 percent of the actual salary, signing bonus, and benefits paid to the NPP or an amount calculated by taking the receipts of services provided by the NPP and subtracting the actual salary, signing bonus and benefits paid to the NPP.

  - **Duration of Assistance:** The hospital, FQHC, or RHC may not provide assistance for a period longer than the first two consecutive years of the NPP's employment by the physician.
- To protect against gaming of the system and rotating NPPs through multiple physician practices, CMS proposed that for the three years prior to being employed by the physician, the NPP must not have practiced in the geographical area served by the hospital, FQHC, or RHC or have been employed by or otherwise engaged by a physician's medical practice located in the geographic area served by the hospital, FQHC, or RHC.
- CMS proposed to define a referral by an NPP to include a request by an NPP that includes the provision of designated health services (DHS) payable under Medicare, establishment of a plan of care by the NPP that includes the provision of DHS, or the certifying or recertifying the need for DHS. The proposed definition would not include DHS personally performed by the NPP.
- CMS proposed that documentation of the remuneration provided under this exception must be maintained for a period of six years.
- CMS proposed that the physician may not impose practice restrictions on the NPP that would unreasonably limit the ability of the NPP to practice in the geographical area served by the hospital, FQHC, or RHC.

Other requirements to safeguard against program or patient abuse are similar to the requirements found in the other Stark exceptions in 42 C.F.R. § 411.357, such as the arrangement must be signed in writing (including signatures of the hospital, physician, and NPP), must represent fair market value, and may not be conditioned on the physician's or the NPP's referrals to the hospital.

CMS is seeking comments on the proposed limitations. Specifically, CMS is seeking comments on whether the exception should be expanded to include more services than only primary care services and more types of practitioners beyond those listed in the proposed rule; whether the exception should apply to the recruitment of independent NPPs; whether there should be a limit to the number of times a hospital, FQHC, or RHC may assist the same physician with the employment of an NPP; the effectiveness and impact of the cap; and whether the exception should include additional safeguards.

Defining *Geographic Area* Served by FQHCs and RHCs

The physician recruitment exception at 42 C.F.R. § 411.357(e) permits a hospital, FQHC, and RHC to provide remuneration to a physician to induce the physician to relocate his or her medical practice to the geographic area served by the hospital, FQHC, or RHC in order to become a member its medical staff. CMS intended for the definition of *geographic area served by the hospital* at 42 C.F.R. § 411.357(e)(2)(i) & (iii) to apply to the recruitment of physicians by FQHCs and RHCS in the same manner as the definitions apply to hospitals. The current definition of *geographic area served by the hospital* is contingent on the volume of the hospital's inpatients. However, FQHCs and RHCs provide primary care services in rural or underserved areas and thus have no inpatients. CMS recognized that the current definition does not provide any guidance to FQHCs and RHCs as to the geographic area into which such an entity may recruit a physician. Therefore, CMS is proposing to revise 42 C.F.R. § 411.357(e)(6) to add a new definition of the geographic area served by a FQHC or RHC in order to appropriately capture the areas where their patients actually reside.

CMS proposed the following two alternative definitions:

1. [T]he geographic area served by a FQHC or RHC is the area composed of the lowest number of contiguous zip codes from which the FQHC or RHC draws at least 90 percent of its patients, as determined on an encounter basis. If the FQHC or RHC draws fewer than 90 percent of its patients from all of the contiguous zip codes from which it draws patients, the geographic area served by the

FQHC or RHC may include noncontiguous zip codes, beginning with the noncontiguous zip code in which the highest percentage of its patients reside, and continuing to add noncontiguous zip codes in decreasing order of percentage of patients. The geographic area served by the FQHC or RHC may include one or more zip codes from which it draws no patients, provided that such zip codes are entirely surrounded by zip codes in the geographic area from which it draws at least 90 percent of its patients.

2. [T]he geographic area served by a FQHC or RHC [is] the area composed of the lowest number of contiguous or noncontiguous zip codes from which the FQHC or RHC draws at least 90 percent of its patients, as determined on an encounter basis. This would be determined by beginning with the zip code in which the highest percentage of the FQHC's or RHC's patients reside, and continuing to add zip codes in decreasing order of percentage of patients.

CMS is seeking comments about the alternative definitions and whether patient encounters is the appropriate measure for determining the geographic area served by an FQHC or RHC. CMS is also seeking comments regarding the barriers FQHCs and RHCs face when recruiting physicians in light of the physician recruitment exception, 42 C.F.R. § 411.357(e).

Conforming Terminology: *Takes into Account*

CMS is proposing to conform terminology used for the volume and value standard in compensation exceptions. Most Stark compensation exceptions use the phrase *takes into account* the volume or value of referrals by the physician, but some Stark compensation exceptions use a different phrase to mean the same thing, such as *based on* or *without regard to*. CMS is concerned that the use of different phrases pertaining to the volume or value of referrals may cause the industry to conclude incorrectly that there are different volume or value standards in the compensation exceptions. CMS is proposing to revise the following compensation exceptions to use the phrase *takes into account*:

- Physician Recruitment Exception at 42 C.F.R. § 411.357(e)(1)(iii)
- Medical Staff Incidental Benefits Exception at 42 C.F.R. § 411.357(m)
- Obstetrical Malpractice Insurance Subsidies Exception at § 411.357(r)
- Professional Courtesy Exception at 42 C.F.R. § 411.357(s)

Retention Payments in Underserved Areas

In Stark II, Phase II, CMS created the retention payments in underserved areas exception at 42 C.F.R. § 411.357(t) to permit a hospital (or FQHC or RHC) to provide a retention payment to a physician whose practice is located in an underserved area. The exception covers retention payments made by a physician who has a bona fide firm, written recruitment offer that would move his or her practice at least 25 miles and outside of the geographic area served by the hospital (or FQHC or RHC) making the retention payment.

In Stark II, Phase III, CMS revised the exception to permit a hospital (or FQHC or RHC) to make a retention payment if the physician certifies in writing that he or she has a bona fide opportunity for future employment that meets the requirements at 42 C.F.R. § 411.357(t)(2). CMS also explained in Stark II, Phase III that a retention payment based on a physician certification may:

not exceed the lower of the following: (1) an amount equal to 25 percent of the physician's current annual income (*averaged over the previous 24 months*) using a reasonable and consistent methodology that is calculated uniformly; or (2) the reasonable costs the hospital would otherwise have to expend to recruit a new

physician to the geographic area served by the hospital in order to join the medical staff of the hospital to replace the retained physician. (72 Fed. Reg. 51066). (emphasis added).

However, 42 C.F.R. § 411.357(t)(2)(iv) currently states that the retention payment may not exceed the lower of "[a]n amount equal to 25 percent of the physician's current income (*measured over no more than a 24-month period*), using a reasonable and consistent methodology that is calculated uniformly…" (emphasis added).

In the proposed rule, CMS stated that the current regulation appears to permit a hospital (or FQHC or RHC) to make a retention payment that is considered only part of the prior 24-month period instead of the entire period. CMS is proposing to modify the text in 42 C.F.R. § 411.357(t)(2)(iv) to reflect the language in Stark II, Phase III, or "averaged over the previous 24 months."

This article is part of Ober|Kaler's client alert "CMS Drives Change in Quality, Physician Payment, and Stark in Proposed 2016 Physician Fee Schedule." View other installments of the alert at these links:

- Changes Are Afoot for Quality Measures and Physician Payment Provisions
- Stark Regulations: Proposed Physician Recruitment Provisions
- Stark Regulations: Proposed Physician-owned Hospitals Provisions
- Stark Regulations: Technical Revisions
- Proposed 2016 Physician Fee Schedule Would Impact Medicare Shared Savings Program