

Guidelines and Strategies for Navigating Stark's Physician Recruitment Exception

White Paper



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TABLE OF CONTENTS

Introduction.....	3
Stark’s Prohibitions and Penalties	4
A Detailed Examination of Stark’s Physician Recruitment Exception.....	5
Geographical Service Area	5
Allocated Expenses for Group Practices and Other Areas of Concern	7
Recruitment of Non-Physician Practitioners	8
Other Considerations When Recruiting Physicians	8
Tips for Navigating Stark’s Physician Recruitment Exception	10
Stark-Based Recruitment Tips.....	10
Community Needs Assessment Tips.....	12
Summary/Conclusions.....	12

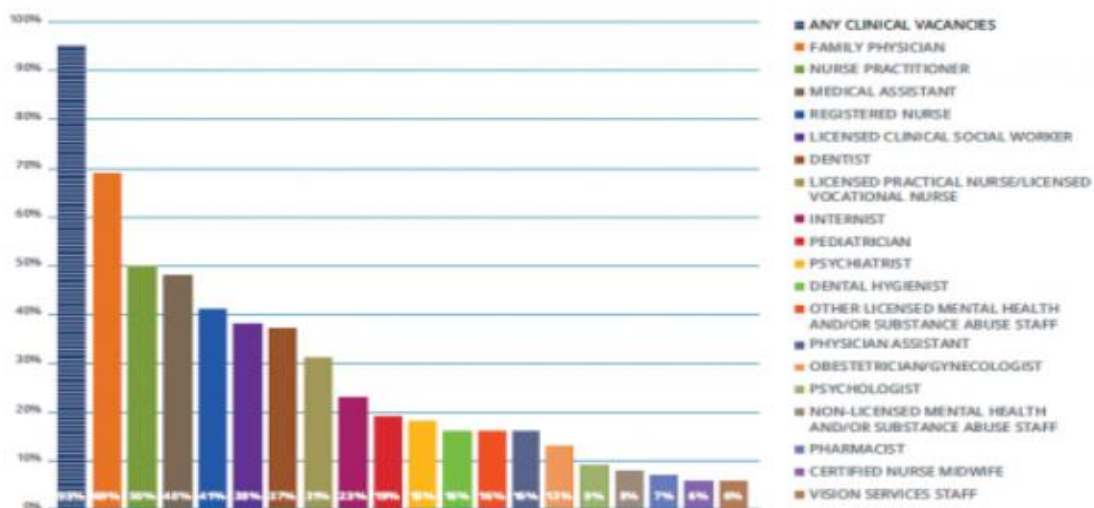
Abstract: For a hospital or health system to continue to meet the healthcare needs of its community, that hospital should have a program that allows for the recruitment of high-caliber physicians that is compliant with the various Stark and IRS regulations. This paper will discuss the Stark and IRS regulations as well as provide tips to providers on how to navigate these regulatory challenges.

Key Words: Stark, False Claims Act, physician recruitment, exception, designated health service area, physician, non-physician practitioner, CMS, rural, objective party, community needs assessment, health professional shortage area, medically underserved area

INTRODUCTION

Health systems, hospitals, and clinics of all sizes must have a robust physician recruitment plan to remain a leading and respected healthcare organization within the community. Physicians leave organizations for a number of reasons, and recruitment plans are vital to any organizational succession planning. As is demonstrated by Figure 1 below, at least 90% of all health centers have a need to fill a specific clinical physician at any one time. Recruiting physicians is a long process. Estimates are that from the time the organization recognizes a need to add a new physician to the time the recruited physician becomes acclimated to the organization could take 24 months.¹ This delay in acclimation emphasizes the importance of having an established physician recruitment plan. For providers in rural areas, the need for a physician recruitment plan is accentuated.

Figure 1: Percent of Health Centers Reporting a Vacancy for Specific Clinical Position²



¹ *Recruitment Important for Keeping Your Practice in 'In Play,'* PYA, (last accessed August 15, 2016), <http://www.pyapc.com/recruitment-important-keeping-practice-play/>.

² *Chair Column April 26, 2016*, Boston University Medical Campus Family Medicine, (April 26, 2016) (last accessed October 31, 2016), <http://www.bu.edu/familymed/news/>.

The ability of a hospital or health system to recruit and retain high-caliber physicians in rural areas is crucial. Despite roughly 25% of the U.S. population living in non-urban locations, residents in these regions struggle to have access to the same quality of care as their urban counterparts.³ For example, while only 10% of U.S. physicians practice in rural areas, rural residents have access to 40 specialists per 100,000 residents as compared to 134 specialists per 100,000 inhabitants in urban areas.⁴ Further, there are 20 more male deaths per 100,000 residents and ten more female deaths per 100,000 in rural areas than those of urban populations.⁵ For these and other reasons, hospitals must ensure that they are serving the community's needs by having a program in place that recruits and retains high-caliber physicians. However, in doing so, these hospitals and health systems need to be wary of the regulatory traps contained within the Physician Self-Referral Law's ("Stark") for physician recruitment. Failure to heed these requirements could result in the organization and provider being required to pay back millions of dollars in civil monetary penalties.

This white paper first will outline the requirements, exceptions, and potential penalties for Stark violations. Next, this article will discuss the physician recruitment exception as well as the regulatory traps contained within the exception. Third, this review will discuss the relevant IRS requirements for physician recruiting as well as detail the benefits (in regards to physician recruiting) of the hospital being located in an area that is medically underserved. Finally, this paper will discuss strategies to help navigate the various regulatory challenges of physician recruiting.^{6,7}

STARK'S PROHIBITIONS AND PENALTIES

Stark states, "If a physician (or an immediate family member of such physician) has a financial relationship with an entity...then the physician may not make a referral to the entity for the furnishing of designated health services⁸ for which payment otherwise may be made."⁹ Stark

³ *What's Different about Rural Health Care?*, National Rural Health Association, (last accessed July 25, 2016), <http://www.ruralhealthweb.org/go/left/about-rural-health/what-s-different-about-rural-health-care>.

⁴ *Id.*

⁵ *Id.*

⁶ The physician recruiting safe harbors of the Anti-Kickback Statute is outside the scope of this white paper.

⁷ While other governmental entities have various rules and regulations regarding physician recruitment, the scope of this White Paper only focuses on Stark's regulations regarding physician recruitment.

⁸ Designated health services include "clinical laboratory services; physical therapy services; occupational therapy services; radiology services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; inpatient and outpatient hospital services; and outpatient speech-language pathology services." 42 U.S.C.S. § 1395nn(h)(6) (LEXIS current through PL 114-195).

⁹ *Id.* at § 1395nn(a)(1)(A) (LEXIS).

defines a financial relationship as “an ownership or investment interest in the entity or a compensation arrangement between the physician and the entity.”¹⁰

Stark is a strict liability statute, which means a violation could occur regardless of whether a provider intends to violate the law. If an arrangement violates Stark and does not fit within an exception, that provider is liable for a civil monetary penalty of \$15,000 **for each claim that violates Stark**.¹¹ Because a Stark violation constitutes a False Claims Act¹² violation if the transaction occurs with the knowing and willful intent of violating Stark, the provider could be liable for treble (i.e., triple) damages.¹³ For transactions that constitute hundreds of unlawful claims, such as those that result from an unlawful employment and/or recruitment arrangement, the penalties could reach into the hundreds of millions of dollars.¹⁴

As stated above, realizing that almost every physician-related transaction could violate Stark, Congress created several exceptions for arrangements that would otherwise not be in compliance with Stark, including a physician recruiting exception. This exception states that a hospital may compensate a physician for the purpose of relocating to the hospital’s geographic area if “(1) the physician is not required to refer patients to the hospital; (2) the amount of remuneration under the arrangement is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician; and (3) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.”¹⁵

A DETAILED EXAMINATION OF STARK’S PHYSICIAN RECRUITMENT EXCEPTION

GEOGRAPHICAL SERVICE AREA

First and foremost, it is important to understand that the physician recruitment exception applies to hospitals, federally qualified health centers, and rural health clinics, as well as providers who are joining an established medical group.¹⁶ The Stark II, Phase III regulations state that a recruited physician must relocate his or her practice to the hospital’s geographical service

¹⁰ *Id.* at § 1395nn(a)(2)(A) (LEXIS).

¹¹ *Id.* at § 1395nn(g)(3) (LEXIS).

¹² See 31 U.S.C.S. § 3729-3733 (LEXIS current through PL 114-195).

¹³ *Id.* at § 3729(a)(1)(G) (LEXIS).

¹⁴ See generally *U.S. ex rel. Drakeford v. Tuomey*, 792 F.3d 364 (4th Cir. 2015) (holding Tuomey liable for approximately \$236 million in damages for violating Stark and False Claims Act); See generally Joe Carlson, *\$85M settlement reached in Florida Stark case*, Modern Healthcare, (July 25, 2016) (last accessed October 31, 2016), <http://www.modernhealthcare.com/article/20140303/NEWS/303039970> (Halifax Health Medical Center settles Stark allegations for \$85 million).

¹⁵ § 1395nn(e)(5) (LEXIS).

¹⁶ Stark II final rule, Phase III, 72 Fed. Reg. 51048; 42 C.F.R. § 411.357(e)(6) (2016).

area “to become a member of the hospital’s medical staff.”¹⁷ Along with relocating his or her practice to the relevant service area, the physician must either “(i) move the site of his or her practice a minimum of 25 miles; or (ii) derive at least 75% of his or her practice’s revenues from services provided by to new patients.”¹⁸

Recently, questions have arisen as to how to determine the geographic service area. CMS defines the geographic service area as the “the area comprised of all of the contiguous zip codes from which the hospital’s inpatients are drawn when the hospital draws fewer than 75% of its inpatients from contiguous zip codes.”¹⁹ For hospitals that are located in rural areas, the geographic service area may be calculated by “using an alternative test that encompasses the lowest number of contiguous (or in some cases, noncontiguous) zip codes from which the hospital draws at least 90% of its patients.”²⁰

For those that do not draw 90% of its inpatient revenues from contiguous zip codes, CMS states, “[the] geographic area served by the hospital may include noncontiguous zip codes, beginning with the noncontiguous zip code in which the highest percentage of the hospital’s inpatients resides, and continuing to add noncontiguous zip codes in decreasing order of percentage of inpatients.”²¹ Finally, a rural hospital may recruit a physician into an area outside of the geographical area “if it is determined by the Secretary in an advisory opinion issued under section 1877(g)(6) of the Act that the area has a demonstrated need for the recruited physician.”²² If contiguous zip codes surround a “hole” zip code, the recruited physician may locate their practice to the “hole” zip code if no inpatients reside in this “hole” zip code.²³

Some questioned whether these regulations permitted physicians whose practices were outside of the geographical service area to either move to a zip code where the hospital drew 75% of its inpatients or whether the practice could relocate their practices 25 miles to an area that was not in the hospital’s geographic service area. CMS clarified this question by stating that the practice must relocate to an area inside the geographical service area and that the practice could either locate to a zip code where the hospital receives 75% of its inpatients (that is in the geographical service area) or the practice can be relocated at least 25 miles to an area that is within the hospital’s geographic service area.²⁴

¹⁷ 72 Fed. Reg. 51048.

¹⁸ 42 C.F.R. § 411.357(3)(2)(iv) (2016).

¹⁹ 72 Fed Reg. 51048.

²⁰ *Id.*

²¹ 72 Fed. Reg. 51050.

²² *Id.*

²³ *Id.*

²⁴ *Id.*

ALLOCATED EXPENSES FOR GROUP PRACTICES AND OTHER AREAS OF CONCERN

Hospitals may pay a guaranteed amount of compensation to a recruited physician; however, “the practice may only allocate costs to the recruited physician that do not exceed the actual incremental costs attributed to the recruited physician. Allowable costs are costs the practice would not have incurred but for hiring the recruited physician, such as the expenses associated with additional equipment, support staff, or malpractice insurance premiums that are incurred solely because of the new physician.”²⁵ For rural hospitals or federally qualified health centers who recruit physicians who replace a physician who is deceased, is retiring, or is relocating, the payments to the recruited physician cannot exceed the actual additional incremental costs attributable to the recruited physician or the lower of a per capita allocation or 20% of the practice’s aggregate costs.²⁶

Hospitals may pay the fees associated with headhunters; airfare, hotel, meals, and other expenses related to visits by the recruited physician and his or her family to the relevant geographical area; moving expenses; telephone calls; and tail malpractice insurance covering the physician’s prior practice.²⁷

Further, the hospital may restrict the recruited physicians in the following manner²⁸:

- Restrictions on moonlighting;
- Prohibitions on soliciting patients and employees of the physician practice;
- Requiring that a recruited physician treat Medicaid and indigent patients;
- Requiring that a recruited physician not use confidential or proprietary information of the physician practice;
- Requiring the recruited physician to repay losses of his/her practice that are absorbed by the physician practice more than any hospital recruitment payments; and
- Requiring the recruited physician to pay a predetermined amount of reasonable damages if the physician leaves the practice and remains in the community.

Before transitioning to recruitment regulations concerning non-physician practitioners, it is important to address how Stark’s recruitment exception interplays with Stark’s employment exception.²⁹ If a provider is recruiting a physician to provider services within the hospital’s geographic service area, and that hospital intends to enter into an employment arrangement with that recruited physician, it is not enough to comply with Stark’s employment exception. The organization must also ensure that the arrangement complies with Stark’s recruiting

²⁵ William Horton, *Relationship Between Physicians and Hospitals*, BLOOMBERG BNA, (last accessed July 28, 2016).

²⁶ 42 C.F.R. § 411.357(e)(4)(iii)(A-B) (2016).

²⁷ Horton, *supra* note 22.

²⁸ *Id.*

²⁹ See 42 U.S.C.S. § 1395nn(e)(2) (LEXIS current through P.L. 114-200).

exception (as well as a host of other recruitment regulations from the IRS, OIG, and other regulatory organizations). In other words, it is not enough to comply with only one Stark exception; often an organization must fit an arrangement into multiple exceptions depending on the circumstances of the transaction.

RECRUITMENT OF NON-PHYSICIAN PRACTITIONERS

CMS recently published their Phase V Stark regulations, wherein CMS created an additional exception for hospitals to pay non-physician practitioners (“NPP”)³⁰ provided hospital and physician practice meets the following conditions:

1. The NPP has not, within one year of the commencement of his or her compensation arrangement with the physician:
 - a. Practiced in the geographic area served by the hospital; or
 - b. Been employed or otherwise engaged to provide patient care services by a physician or a physician organization that has a medical practice site located in the geographic area served by the hospital, regardless of whether the NPP furnished services at the medical practice site located in the geographic area by the hospital
2. Substantially all of the services that the NPP provides to patients of the physician’s practice are primary care services or mental health care services; and
3. The physician or physician practice does not impose unreasonable restrictions on the NPP’s ability to practice in the hospital’s geographic area.³¹

Further, the regulations state that the arrangement must be in writing and that it must be between the physician practice and the NPP. The NPP’s compensation cannot be conditioned on the volume or value of the NPP’s referrals, and it must be of fair market value. Third, the compensation from the hospital cannot exceed 50% of the NPP’s actual compensation, signing bonus, and benefits paid by the physician to the NPP during a period not to exceed the first two consecutive years of the compensation arrangement between the NPP and the physician.

OTHER CONSIDERATIONS WHEN RECRUITING PHYSICIANS

For non-profit organizations, one must pay careful attention to IRS regulations so as not to jeopardize the organization’s 501(c)(3) non-profit status.³² For hospitals that provide

³⁰ Stark V regulations define NPP as a physician assistant, nurse practitioner, clinical nurse specialist, certified nurse-midwife, clinical social work, or a clinical psychologist. *Assistance to compensate a non-physician practitioner*, 42 C.F.R. § 375(x)(3) (2016).

³¹*Assistance to compensate a non-physician practitioner*, 42 C.F.R. § 357(x) (2016).

³² In recent years the government has begun to examine the organizational goals of non-profit hospitals. In some instances, the hospital lost its non-profit status, resulting in the hospital being forced to pay back

recruitment incentives, “the organization [must meet] the operation test by showing that, taking into account all of the benefits provided the physician by the organization, the organization is paying reasonable compensation for the services the physician is providing in return.”³³ For those providers that are providing medical services to the community but not necessarily on behalf of the hospital, the following four requirements must be met:

1. The organization may not engage in substantial activities that do not further the hospital’s exempt purposes or that do not bear a reasonable relationship to the accomplishment of those purposes;
2. The organization must not engage in activities that result in inurement of the hospital’s net earnings to a private shareholder or individuals;
3. The organization may not participate in public interest so that it has a substantial non-exempt purpose; and
4. The organization may not engage in substantial unlawful activities.³⁴

The IRS has consistently held in both private and public revenue rulings that “for incentives to be offered by an organization, i.e., recruitment-based compensation, objective evidence needs to be provided, in the form of a needs assessment, demonstrating a need for physicians in the service area.”³⁵ The incentives must be reasonable and not result in any of a hospital’s net earnings inuring to the benefit or any of the recruited physicians.³⁶

While Stark (as opposed to the Anti-Kickback Statute and other IRS regulations) does not currently require an objective community needs assessment, arrangements can easily implicate other anti-fraud statutes such as the Anti-Kickback Statute and False Claims Act, and such recruitment benefits can also place an organization’s tax-exempt status at risk. Therefore, hospitals looking to recruit physicians would be wise to seek a community needs assessment from an object third party before recruiting any physician or non-physician practitioners. In addition to taking into consideration the community needs assessment, it is also important to determine whether the hospital is located in an area that is medically underserved.

Many benefits can be derived by determining if the hospital is located in an area of need. Recruiting physicians to a health professional shortage area (“HPSA”) and medically underserved area (“MUA”) allows the hospital or health system to more easily and less expensively recruit foreign-educated physicians since they would be eligible for a J-1 and H-1B visa waiver. As is demonstrated by Figure 2, much of the United States is in need of primary care physicians.

millions of dollars in property taxes. See Rob Meiksins, *Judge Terms Modern Nonprofit Hospitals a ‘Legal Fiction,’* Nonprofit Quarterly, (July 7, 2015) (last accessed October 31, 2016), <https://nonprofitquarterly.org/2015/07/07/judge-terms-modern-nonprofit-hospitals-a-legal-fiction/>.

³³ IRS Revenue Ruling 97-21.

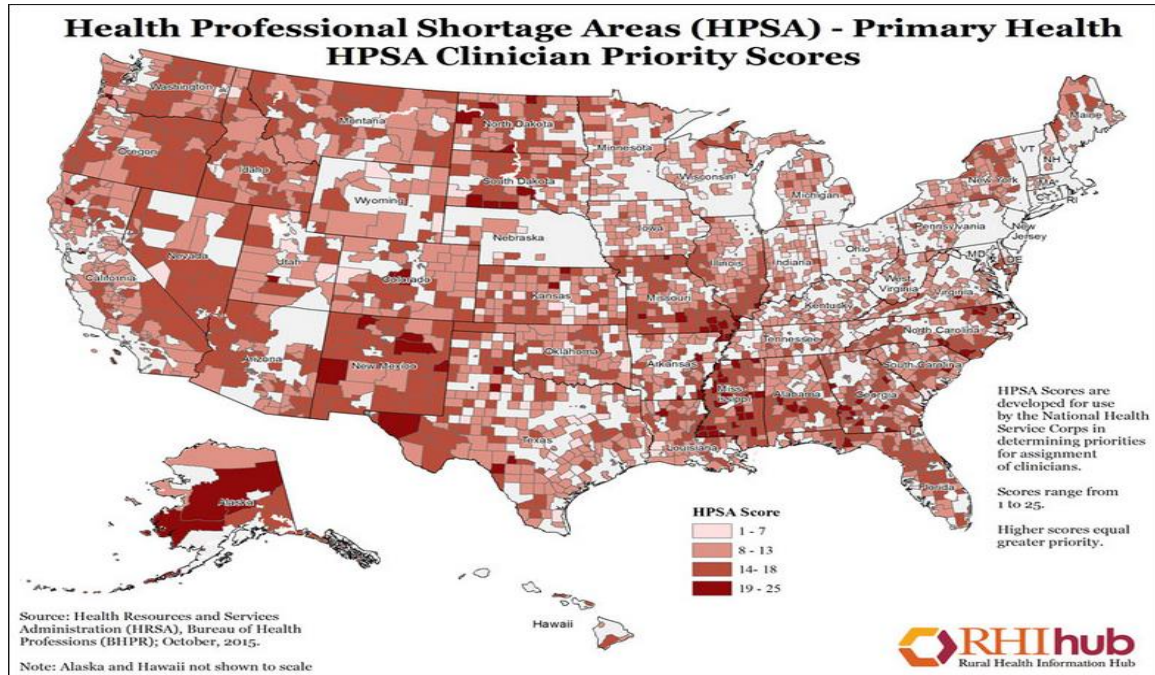
³⁴ *Id.*

³⁵ IRS Private Revenue Ruling, July 1998, *citing*, Rev. Rul. 73-313, 1973-2 C.B. 174.

³⁶ *Id.*

Physicians recruited to these areas may have a substantial amount of their student loans forgiven as well as receive a 10% bonus on their Medicare reimbursement rates.³⁷ HPSA area hospitals are not only considered rural health clinics (whose benefits are outlined above), but hospitals in these areas are more likely to receive financial assistance from the government.³⁸

Figure 2



TIPS FOR NAVIGATING STARK’S PHYSICIAN RECRUITMENT EXCEPTION

STARK-BASED RECRUITMENT TIPS

To comply with the physician recruitment exception, the question the organization should answer is whether there is a need for a physician within the community. The governing body of the organization should consider factors such as community demographics, the number of physicians in the different specialties, as well as studies performed by independent parties assessing the needs of the relevant community, as well as considering interviews with medical staff and those in the community regarding the need for more medical care.³⁹

³⁷ *Loan Repayment Program*, U.S. Dept. Health & Hum. Serv., (last accessed August 7, 2016), <http://nhsc.hrsa.gov/loanrepayment/>; *Physician Recruitment and Community Building*, HPSA Acumen, (last accessed August 7, 2016), <http://www.hpsa.us/benefits-of-designation/physician-recruitment>.

³⁸ *Id.*

³⁹ Ann DesRuisseaux, Donald Romano and Lisa Ohrin, *Physician Recruitment: Ensuring Stark Compliance, Avoiding Fraud and Abuse Pitfalls when Crafting and Evaluating Recruitment Policies and Agreements*, Strafford 22, (January 14, 2010) (last accessed October 31, 2016), accessed at

The next step should be to determine the geographic service area of the hospital. It's important to remember that the geographic service area must be determined by the hospital and not by the health system. If a geographic service area cannot be determined by the methods stated above, then the hospital will not be able to use Stark's physician recruitment exception to employ the physician.

In addition to relocating the physician's practice to an acceptable area as outlined above, it is a good idea for the remuneration to be passed directly to the recruited physician. Further, the practice must maintain records of the actual costs and the passed through amount for at least five years (and six years for NPP compensation agreements) and [be made] available to the Secretary and the Hospital" upon request.⁴⁰

It is vitally important to ensure that every detail of the employment arrangement is stated in the written employment agreement. The employment agreement should also state that there is no agreement or private understanding that the physician is expected to utilize hospital facilities during the course of their care provided to the physician's payments. Hospitals should describe the community need in vague terms so as not present the appearance of a promise of revenue to the hospital.⁴¹

Hospitals should keep in mind that CMS disfavors renegotiations of provisions that substantially affect a physician's compensation after the physician has been recruited by the hospital or health system, even if those provisions violate Stark.⁴² Parties must wait until the term of the agreement expires to enter into a new agreement that complies with Stark. Considering CMS's position, it is important to ensure that physician employment agreements are Stark-compliant before they are executed by the hospital and the recruited physician.

<http://media.straftfordpub.com/products/physician-recruitment-ensuring-stark-compliance-2010-01-14/speaker-handouts.pdf>.

⁴⁰ *Id.* at 25.

⁴¹ *Id.* at 31.

⁴² "With respect to the question of whether the parties may delete the excess receipts provision in the Amended Agreement, although the recruitment exception in 42 C.F.R. § 411.357(e) does not require the use of an excess receipts provision such as the one contained in the Arrangement, we conclude the parties cannot now delete it from the Arrangement. The purpose of the physician recruitment exception is to permit certain compensation arrangements to induce a physician to relocate his or her medical practice to the geographic area served by a hospital in order to become a member of the hospital's medical staff. We do not believe that the parties should now be able to amend the Arrangement to provide for additional (or potentially additional) compensation to the Physician. Because the Physician has already relocated his medical practice, the additional compensation is not for the purpose of inducing relocation and may directly or indirectly reflect the volume or value of the recruited physician's actual or potential referrals." See Centers for Medicare and Medicaid Services, Advisory Opinion 2007-01 at 5.

COMMUNITY NEEDS ASSESSMENT TIPS

Regarding the community needs assessment that the recruiting organization should perform, it is recommended that the population-to-physician ratio in the zip code of the new practice location is below the ration in an accepted benchmark as demonstrated by a qualified and experienced consultant.

Waiting periods or travel times for patients seeking specialty services in the geographic service should exceed the statewide or national averages for wait times. Otherwise, it would be difficult to justify that a community need for that specialty. Further, the practice should be designated as a Health Professional Shortage Area or as a Medically Underserved Area.

Finally, the recruited physician should agree to serve a substantial number of patients who reside in a zip code with a population-to-physician ratio below the ideal ratio; are part of a medically underserved population or who reside in a health professional shortage area, medically underserved area, or isolated rural area. The recruited physician should also agree to staff a new facility or service in the community that has obtained a certificate of need pursuant to state law (which process includes an examination of the need for the service or facility in the community). The employment agreement should memorialize these commitments.

SUMMARY/CONCLUSIONS

In conclusion, hospitals and health systems must ensure they have a strategy that allows them to recruit and retain high-caliber physicians. In doing so, hospitals and health systems must be aware of the many regulations that pertain to physician recruitment. Failure to adhere to these regulations could result in severe Stark penalties, as well as the loss of a hospital or health system's 501(c)(3) non-profit status. Central to any recruitment plan is the performance of the community needs assessment by an objective third party, as it will demonstrate that there is a need within the community for the recruited physician, as well as that the compensation paid to the physician does not result in an improper benefit to any other member of the organization.