Stark: Lights Out on Per-click and Percentage-Based Leases?

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Practice Area: Health Law

The utility of per-click and percentage-based compensation arrangements has taken another hit. The Centers for Medicare and Medicaid Services ("CMS") has released final rules under the Stark physician referral statute that substantially limit the use of these payment methodologies in space and equipment leases between physicians and the hospitals and other entities to which they refer.

Background. The Stark physician self-referral rules prohibit a physician from making referrals of certain "designated health services" ("DHS") to an entity with whom the physician has a financial relationship, and prohibits the entity from billing Medicare for those services, unless an exception applies. Several of those exceptions require that the compensation under the financial relationship must be "set in advance."

Over the tortured history of Stark, CMS has frequently revisited how the "set in advance" requirement applies in situations where the compensation is based on periods of time, units of service (frequently referred to as "per click" arrangements), or formulae such as percentage of revenues or collections. Section 411.354(d) of the Stark regulations states that compensation is considered to be "set in advance" if the aggregate compensation, a time-based or per-unit amount, or a specific formula for calculating the compensation, is set forth in an agreement between the parties before the furnishing of the items or services for which the compensation is to be paid.

In July 2007, CMS proposed further clarifications on the "set in advance" standard in its CY 2008 Physician Fee Schedule proposed rule. CMS stated that arrangements where a physician lessor received per-click payments were inherently susceptible to abuse, given that the physician had a financial incentive to refer a higher volume of patients to the lessee, and therefore proposed that such arrangements would not qualify under the Stark exceptions for space and equipment leases. CMS also proposed to allow percentage-based formulae only when paying for personally performed physician services, again due to concerns over abusive arrangements where lease charges were tied to revenues earned by the lessee, thereby creating a financial incentive for the lessor to increase referrals of business to the lessee.

CMS has now incorporated its CY 2008 PFS proposals into a final rule. In its preamble, CMS again details its ongoing concerns regarding abusive compensation arrangements that create improper incentives for physician referrals. CMS emphasized that virtually all of the comments that it had received from hospital organizations in response to the CY 2008 PFS proposed rule were in favor of the restrictions advanced by CMS.

Per-click arrangements. CMS has repeatedly expressed concern over arrangements where physicians purchase equipment and then lease it to hospitals, with the hospital paying a rental fee for each use (or "click") of the equipment. Typically, the physicians are specialists who refer patients to the hospital for procedures that require use of the equipment, such that the aggregate rent received by the physicians varies with the volume of the physicians' referrals to the hospital. Per-click arrangements come in all stripes, including imaging services, surgical lasers, brachytherapy, cryotherapy, and others.

The new final rule prohibits per-click payments to a physician lessor where the payments reflect services provided to patients referred by the physician to the lessee. Both equipment and office space leases are covered by the rule. CMS adopted this rule in an effort to reduce, if not eliminate, the ability of a physician to profit directly from the physician's referrals of DHS. According to CMS, this financial incentive may (a) result in overutilization through the ordering of unnecessary services; (b) encourage physicians to steer patients to the lessee of the physician's space or equipment rather than to other entities that may employ a different treatment methodology (or in some cases, may recommend no treatment at all), thereby narrowing the range of treatment options to those for which the physicians receive a profit; and (c) foster anti-competitive behavior as entities enter into relationships due to the fear of losing the physician-lessor's referrals.

CMS received numerous comments in response to the CY 2008 PFS proposed rules, to the effect that such arrangements are abusive and that hospitals are effectively coerced into such arrangements out of fear that they otherwise will lose their referral streams. According to commenters, hospitals may be thwarted in their efforts to bring in certain types of new technologies, such as lasers, unless physicians have an ownership interest in the equipment. CMS noted its concern over the proliferation of physician-owned equipment providers leasing under per-click arrangements. Indeed, CMS stated that "the fact that per-click arrangements are common for physician-owned entities does not alleviate our concern of overutilization, but rather intensifies it."

CMS rejected arguments that hospitals are inherently risk averse when it comes to low volume procedures, and that per-click arrangements are necessary in order to provide state-of-the-art procedures to the community, particularly in rural areas. CMS was also unpersuaded by arguments that per-click arrangements promote efficiencies by permitting expensive equipment to be utilized by multiple parties. CMS also declined an invitation to treat leases for therapeutic equipment differently than diagnostic equipment, concluding that risks of improper utilization existed for both.

While the focus of the new rule generally is on per-click arrangements where the referring physician is leasing space or equipment *to* the DHS entity, the prohibition on per-click payments may also apply in certain situations where the physician is leasing the space or equipment *from* the entity. This could arise where the physician is submitting claims for DHS rendered to patients referred to the physician by the lessor. This type of arrangement may allow the physician to perform and bill for the technical component services ordered by the physician for the physician's patients. A per-click fee in this situation may create an incentive for overutilization, since the physician may pocket the difference between the rental fee and the reimbursement received by the physician from Medicare. While CMS intended a "symmetrical approach" that would apply to both hospital and physician lessors, the rule falls short of a universal prohibition. Instead, the new rule prohibits arrangements where the rental charges "reflect services provided to patients referred between the parties." Thus, the rule would not prohibit an arrangement where a hospital owns the equipment and leases it to a group of physicians, who then pay a per-click fee to the hospital when the physicians use that equipment for their own patients, so long as the patients have not been referred by one party to the other. Note that while this interpretation is supported by the language of the rule, it still leaves in place an incentive for overutilization relative to the physicians' own patients.

For the most part, the new rules do not affect time-based leases. CMS acknowledged that block scheduling may be a viable alternative to a per-click methodology. By leasing a pre-scheduled block of time, for which the physician receives payment regardless of whether or not the space or equipment is actually in use, the financial incentive for each incremental referral is reduced if not eliminated. This approach is still subject to existing requirements that the lease provisions be commercially reasonable even in the absence of referrals, that the payment be consistent with fair market value, and that the lease of space or equipment does not exceed what is reasonably required by the lessee. In addition, the size of each increment in a block lease must not be so small that the lease essentially functions as a per-click arrangement. CMS acknowledged that time-based arrangements may be subject to abuse, and noted that it may propose additional rule-making in the future. In particular, CMS considers "on demand" rental agreements to be problematic, and it will treat them as a per-use/per-click arrangement under the new rules.

Finally, parties to a lease may not avoid the per-click prohibitions by structuring the agreement as an indirect compensation arrangement, such as through the use of a physician-owned leasing company. Previously, per-click issues usually arose only in the context of leases directly between DHS entities (such as hospitals) and physicians or physician organizations. This was because the lease exception applicable to direct compensation arrangements contained the "set in advance" requirement, while the exception for indirect compensation arrangements – which would apply to arrangements where a physician-owned leasing company is the intermediary – contained no "set in advance" requirement. Under the new rule, however, the indirect compensation exception now incorporates an explicit prohibition on per-click compensation, significantly reducing the advantages of that exception.

Percentage-based arrangements. The final rules adopt a slimmed-down version of the CY 2008 PFS proposals on percentage-based compensation. CMS initially proposed to permit percentage-based compensation only for personally-performed physician services. The final rule takes a different approach: CMS has chosen to prohibit percentage-based compensation only in office space and equipment leases, while permitting a wide variety of other arrangements that do not involve personally-performed physician services.

CMS concluded that percentage-based lease arrangements, like per-click arrangements, pose a heightened risk of program abuse insofar as they provide inappropriate incentives for referrals and may not result in compensation that is fair market value. Using once again the example of a referring physician owning and leasing equipment to a hospital, the physician may not charge rent based on a percentage of revenues generated through use of the equipment, since the physician's profit from the rental would increase as the physician referred more patients to the hospital for procedures using the equipment – just as with a per-click lease. And as with per-click arrangements, CMS was concerned that hospital lessees may enter into percentage-based rather than flat-fee leases out of fear that they otherwise will lose referral streams from the physician lessors.

CMS clarified that the rule does not prohibit a landlord from charging a tenant for a *pro rata* share of expenses related to office space, such as taxes or common areas. CMS does not consider such an allocation of expenses to constitute a percentage-based compensation formula.

As with per-click arrangements, the new prohibitions on percentage-based compensation have been incorporated into the indirect compensation and fair market value exceptions in addition to the lease exceptions. Once again, this is intended to prevent circumvention of the prohibition through alternative structuring as indirect compensation arrangements, or through equipment leases of less than one year in duration (to which the fair market value exception might otherwise apply). CMS will continue to monitor arrangements for abusive behavior, and may expand these restrictions to other percentage-based formulae if necessary to prevent program or patient abuse.

Not all per-click arrangements are affected by the new rules. Basing the aggregate payment on the number of procedures performed on the equipment is not inherently suspect; rather, the problem arises when the physician ordering the procedures is profiting from each referral. For example, hospitals may enter into per-click *leasing* arrangements with equipment leasing companies that are not owned by referring physicians. Even physician-owned entities may charge a per-click rental, so long as they do not use that methodology for services that they refer to the lessee. And perclick arrangements may still be permissible in certain limited situations where it is the hospital that owns and leases property to referring physicians. Generally, though, most existing per-click arrangements will need to be restructured or terminated. As discussed previously, block scheduling arrangements may present a viable alternative so long as they are not "on demand" leases.

Similarly, many percentage-based arrangements are unaffected by the new rule, particularly those not involving leases. Hospitals may still enter into percentage-based arrangements that compensate physicians for their personally-performed services, while academic medical centers and faculty practice plans may also continue to base compensation on a percentage of service-based revenues. Billing agent or management agreements may also continue to peg compensation to a percentage of revenues or collections (subject always to fair market value requirements). And CMS confirmed that the rule does not affect incentive payment and shared savings ("gainsharing") programs, which were the subject of a proposed new exception published this past March in the CY 2009 PFS proposed rule. The new rule only prohibits the use of percentage-based leasing arrangements where the hospital (or other DHS entity) is paying rent based on a percentage of the revenues attributable to the services performed on or business generated by the use of the property. And even in lease arrangements, parties may still allocate expenses on a percentage basis so long as the allocation is not tied to revenues. Existing arrangements that determine rental charges based on a percentage of revenue will need to be restructured, such as through fixed rental fees or an appropriate perclick fee, or they will need to be terminated.

Hospitals should also examine existing agreements where physicians are providing services "under arrangements," as these agreements frequently involve equipment and space leases with perclick or percentage-based compensation provisions. The new Stark rules will significantly impact "under arrangements" agreements in other ways; these changes will be addressed in a separate von Briesen Health Law Bulletin.

Effective Date. The rules are scheduled for official publication in the Federal Register on August 18, 2008.
